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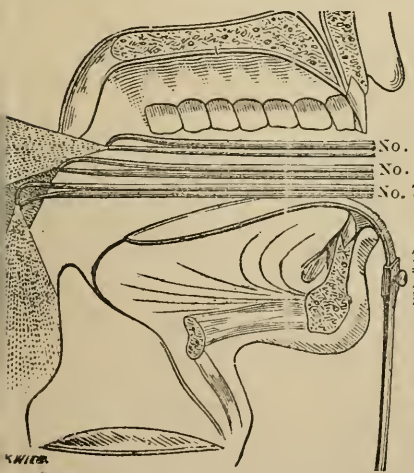

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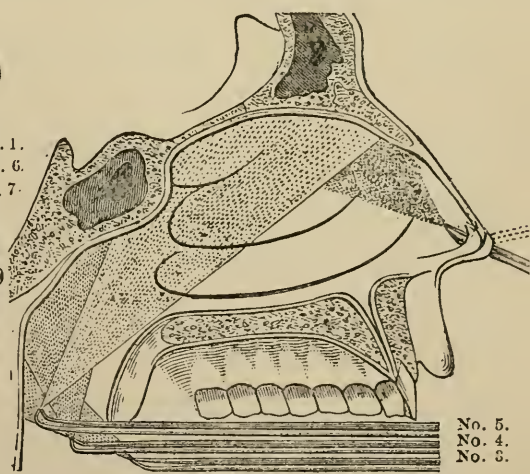

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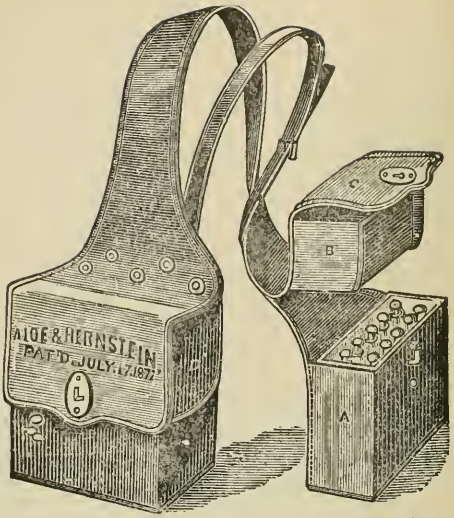

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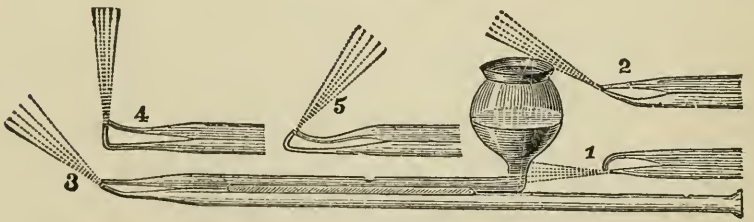

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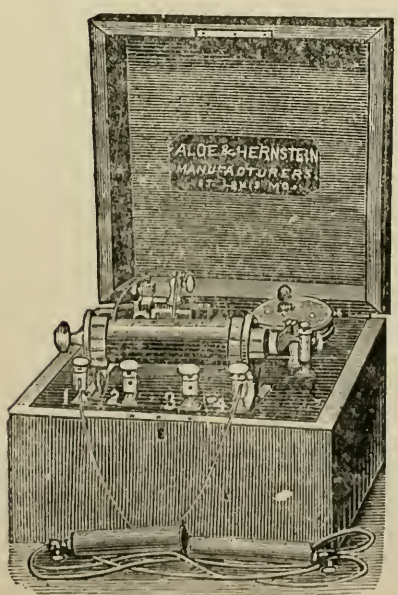

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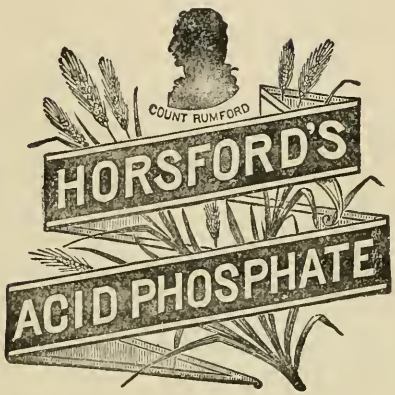

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Let the patient put eight or ten drops of Acid Phosphate into half a glass of cold water, and take a sip of it, say a few minutes before rising or whenever the sickness or nausea is coming on.

It is equally effective in hot water, or tea without milk or sugar, and to some may thus be more palatable. In such cases use the same dilution as above. Some constitutions may need a stronger dilution, which fact, experience alone can decide.

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Physicians desiring to test it will be furnished a bottle free of expense, except express charges.

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Original Contributions.

Article XXXIV.

A Case of Myopia Complicated with Nystagmus. By E. Benkendorf, M. D., of St. Louis.

The following description is that of a case of nystagmus, having come under my observation Feb. 22, 1883. The patient is a girl about thirteen years of age. She has had purulent ophthalmia, this having set in three days after birth. The left eye recovered without any permanent anatomical alteration. The right eye, on the contrary, had become staphylomatous and this deformity had been increasing until a year ago, when the eyeball became suddenly atrophied. She then became near-sighted in the left eye, to an increasing degree, and came to me to receive an order for the proper kind of spectacles. At the same time there was a noticeable nystagmus of the left eye and of the atrophied eyeball of the right eye. Pain, there was none in either the left or right eyeball and had never been, to her recollection.

The nystagmus consisted in lateral or cillatory motions of the left eye and stump of the right one, and was only momentarily arrested when the patient directed her eye in a determined manner upon a fixed object. The motions of the pupil of the left eye were normal and the patient stated that she could see better on a bright day and also at night by artificial light. I may besides, state here, that there are no specks on the cornea of the left eye, nor any cataract in the same. The color of the patient's eye is black.

It seems probable that the nystagmus of both eyeballs and the myopia of the left eye depend on the atrophy of the right eyeball. We do not suppose, however, that ciliary nerve irritation is the immediate cause of the nystagmus and myopia. In proof of this we have to reflect upon the sudden atrophy of the eyeball, which would point to disease of the optic nerve and likely that of the sympathetic. This seems to be corroberated by the fact, that the patient sees better by artificial bright light and warrants the exclusion of ciliary nerve irritation. We fee

inclined to ascribe the atrophy of the right eyeball to absorption of pus from the cornea, and that this infection, inflamed and then paralyzed the optic and sympathetic nerves. It took, of course, several years to perfect these pathological processes.

TREATMENT.—Enucleation of the atrophied right eye seems to be the rational indication for treatment. Patient refused to submit to this operation and desired to get the advice of other medical men.

PROGNOSIS.—The success of enucleation cannot be determined beforehand because the condition of the papilla of the optic nerve cannot be ascertained inasmuch as the ophthalmascope can here be of no use.

ARTICLE XXXV.

ENCEPHALOID OF HEAD OF HUMERUS AND SURROUNDING STRUCTURES. By D. K. DICKINSON, M. D., LEAD CITY, D. T.

On May 21st, 1882, I was called to see Emma C.——, age twelve, Irish. Previous health always good; large and well developed. Family history good. Upon examination the following symptoms were present: Bowels constipated; pulse 100; temp. 100°; tongue clear; complains of pain in head, back and lower limbs. No history of any previous injury except a severe shock in right arm, from a battery, some three weeks before, which she said made her right arm numb for several days after. As I could see no evidence of any positive disease, I simply ordered a cathartic, followed by a few doses of quinine.

On the 24th, was again called and found the pains no better and of a migratory nature affecting groups of muscles alternately. The temperature was normal, appetite good, and general appearance healthy. Ordered opiates to relieve pain. This condition remained the same up to July 5th, when again was recalled and my attention directed to an enlargement of right shoulder which was somewhat swollen, with no redness, pain or tenderness to the touch. Complained of some pain in elbow. Urine very red and scanty; no fever; pulse 100; appetite good;

pains continue in muscles. I certainly was puzzled as to the nature of the case. I requested a consultation, hoping to have more light thrown on the case, but Dr. Connell seemed as much at sea as myself; we concluded to order a general treatment and wait for further developments. From this time on, her general health began to decline and I had to resort to cod liver oil and bark, which soon toned up her system. Temp. still remains normal; urine still scanty. Have to continue opiates to relieve pain, which is yet very severe in body and lower limbs. Her shoulder still continues to increase in size, without discoloration of skin, or showing any tenderness.

On the 15th, noticed that the subcutaneous veins were somewhat enlarged over shoulder and pectoral region. Also found some induration of glands of axilla. There was now a semi-elastic feel to the tumor, not lobulated. Temp. 100°; pulse 100; tongue coated with dark brown line through center. I now satisfied myself that I had a malignant tumor to deal with and requested counsel again. Drs. Joel Houghton and B. B. Kelly were called and after an examination, thought there must be pus in the tumor; this I could not grant, as I had made up my mind that it either was an encephaloid or osteo sarcoma, and consequently would not be likely to contain pus. We determined to aspirate, and found only a drop of dark grumous blood adhering to the needle. We then made an incision about three inches long, down to the bone, which proved to be necrosed. Commencing at the head and extending down the shaft three inches, the shoulder was enlarged about two-thirds more than its fellow. The skin was natural but after getting through this, the handle of the scalpel finished the operation, as the tissues were all soft and broken down, like cerebral matter. I will state the object of making this incision, was for the purpose of securing the neoplastic growth, but after getting down no operation presented itself that promised any relief, as the induration of the glands of the axilla, showed that they were also involed. The oder was that of necrosis and very offensive, the wound was washed out and dressed with antiseptics. We, of course, concluded that it was a helpless case, and ordered paliative treatment accordingly. I remained in charge of the case until the 28th, when the parents thought they would get another doctor who could cure the disease by doctoring the kidneys. I saw her again on the 28th, about two hours before dissolution, I undressed the wound and never

have I experienced such an odor as this case emitted; the wound had not been dressed since my last visit, and consequently was in a very bad condition. She was then comatose and had been so for several hours. Her eyes were puffed and ankles œdematous.

My object in presenting a history of this case is; first, to show the deceptive manner in which it developed; second, its rapid growth and fatal termination.

The enlargement, when first noticed, did not present any of the physical signs of its character; it looked more like a scrofulous abscess, no heat or pain, not lobulated or hard, as these growths usually are when in their infancy. Her general health gave no evidence of the peculiar cachexia that usually accompanies these malignant diseases.

The rapidity of its growth and fatal termination was certainly remarkable, as it is rare for these diseases to run so short a course, generally requiring from three to twelve months before death occurs. Of course, it may be argued, that death occurred from some intercurrent affection, though I hardly think that it could without it being detected, as I was very much interested in the case and consequently gave it very careful attention in connection with two or three other medical gentlemen who were anxious as to diagnosis and result. I was very much disappointed in not being allowed to hold a post-mortem, as I wished to examine the kidneys, which I supposed were not healthy, although I made several examinations of the urine and found it normal so far as specific gravity albumen and reaction was concerned.

Article XXXVI.

Report of a Case of Glio-Sarcoma.* By A. H. Meisenbach, M. D., of St. Louis.

The parents state that at the age of three months, the child fell with its eye, on a sled; nothing particular was noticed until some months afterwards, a friend called their attention to it, and remarked that the child had two kinds of eyes,—that the color was not alike in both.

They took the child to the late Dr. Gebser, at about the age of eighteen months. He kept the child under his notice for some time, having the parents bring the child to his office every ten days, for examination. He had said that, (so parents say) it would be time enough for operative interference, when the child was five years old, as it was too young. This statement must be taken "*cum grono salis*," for the statements of parents or friends in regard to what a physician said or did, are too often at variance with the real facts. Dr. Gebser, in the mean time, died. After a lapse of time, the parents took the child to Dr. Niehaus, who, as parents said, did and said about as did Dr. Gebser. Dr. Niehaus also dying, there was another lapse of time and neglect of the child.

In July of last year I was called to see the father, for pulmonary trouble. I saw the child, and the parents gave me the facts as already stated. The eye, at this time, was the same size of the other; but the pupil was very large, (obliterated) and it was apparent that vision was impaired. I advised them that it was wrong to neglect the child, and that they should not delay to take it to an oculist. They promised to do so, but as before, they did not do it. About August, the eye became inflamed and the parents took him to an occulist, who advised immediate removal. Attending the father still, I saw the case at this time. The eye was much swollen, chemosis severe, and great tension of the globe. Strange as it seems, the people even now, did not

*Read before the St. Louis Medical Society, Feb. 10, 1883.

heed the advice of the oculist, but put it off until the father should feel better so that he could go to the oculist with it.

Not visiting the father at the house any more, I did not see the child until the last week in October. In the course of time, between August and the latter part of October, the parents state that the eye burst and the boy's sufferings were much relieved. When I saw the child again, in the latter part of October, the eye presented the appearance as shown in photograph No. 1. The protruding tumor was a fleshy appearing mass, bleeding on being touched, not painful, moving in response to the contractions of the various muscles of the eye.

The boy was feeble, being unable to walk, and complaining of neuralgia of the limbs; appetite fair.

I advised removal at once. Up to this time I had not known the nature of the affection, but now there was no mistaking it. There was some enlargement of the inferior maxillæ on the left side. The prognosis as to the result, was bad, and the operation could only be paliative.

The operation was somewhat tedious on account of the matted condition of the tissues of the orbit. Reaction was not very great, and the case, as far as the operation was concerned, progressed favorably. The neuralgia also became somewhat better for a few weeks.

Photo No. 2 shows the condition at the end of one month after operation. The neuralgia spoken of, increased also, the enlargement of the lower jaw. On the left scapular a tumor became perceptible, and the tumor removed from the orbit, again began to grow. There was also gradual enlargement of the the shafts of the long bones.

Thus the morbid process continued until the 13th day of January, 1883, one and a half months after the removal of the orbital growth, when death closed the sad scene.

The patient, on account of the condition of the growth of the jaws, was enabled to take only liquid nourishment, and this also towards the last, became hardly possible.

POST-MORTEM.

Body much emaciated. Dissecting out the secondary tumor of the orbit, found that it extended into the frontal region, the bone beneath was roughened and the line of absorption was clearly visible, the malor bone was also roughened, especially

the orbital plate which was also softened and partly broken down. The glands of the cervical region and also of the inguinal region were enlarged

Opening the cranium, found the dura-mater somewhat more adherent, than normal and found inflammatory spots scattered over its surface at the site of inflammatory spots the inner table of the skull was also roughened.

The surface of the pia-mater was somewhat congested, and its surface looked cloudy. Removing the brain it was found that the morbid process traversed the course of the left optic nerve to the optic commissure, (how much beyond, I am not able to state at present.) The left optic nerve to all appearances being normal. Vision seemed to be perfect up to the time of death in the right eye. Removed the tumor from the left scalpula. The mesentric glands were enlarged, otherwise there were no no tumors in the lungs, liver and other internal organs. The shafts of the bones enlarged, especially the left humerus at elbow, and radius and ulna at the wrist.

Article XXXVII.

Comments on Current Literature of the Diseases of the Nose, Throat and Ears. By Thos. F. Rumbold, M. D., of St. Louis.

Dr. Draper reports a case purporting to be croupous inflammation of the pharynx, larynx and trachea, with occlusion of the larger bronchi, to the Suffolk District Medical Society, which is published in the *Boston Med. and Surg. Jour.*, March 1, 1883.

"G. B. P., twenty-two years old, married, and a brakesman, entered Boston City Hospital, Jan. 8, 1883. There was a history of cough of four months' duration, but no other pulmonary symptoms. Present sickness began five days before entrance, with nausea, vomiting, epistaxis, and headache; sore throat; pain in deglutition. Cough abundant, with whitish expectoration. Slight chilliness and anorexia. Some difficulty in breathing for three days, but wheezing respiration and aphonia for two days' duration.

At time of entrance had a croupy cough and difficult breathing. Could speak only in a whisper. Pulse was 120; respiration 28; temperature 103° F. Throat examined by Dr. Prince, who found larynx covered with a grayish deposit which involved the true and false cords. Fauces showed redness only. Steam from an atomizer was inhaled every two hours, and a poultice was applied every four hours to the neck.

He was very restless during the night, and did not sleep. He had six dejections that were loose, but without membrane or blood.

In the morning he had a copper and opium pill, and the spray of salicylate of soda, ten to the ounce. Sherry, two ounces every six hours. He coughed up several pieces of membrane, some as large as a silver dollar.

In afternoon, respirations 28; pulse 148; temperature 102° F. Chest showed good resonance in front, with some sonorous and sibilant râles; some diminished resonance over left back, and feeble respiration. Some laryngeal stridor. Nails and face slightly blue.

Tracheotomy was performed by Dr. Thorndike, and patient lived five hours after operation. During this time he had stimulants freely and steam from atomizer. Breathing was fairly quiet, but pulse rapid and weak. Died very quietly without signs of suffocation.

DR. GARNETT, who had made the autopsy in the case, demonstrated the specimen.

The tonsils were nearly doubled in size, reddened, their crypts filled with partially adhering plugs of fibrine. On the posterior wall of the pharynx were numerous similar patches of fibrine; the mucous membrane beneath being reddened and injected.

A continuous fibrinous false membrane covered the epiglottis, larynx, mucous membrane of trachea and bronchi down to the smallest divisions which could be followed out with fine scissors.

The glottis opening was only large enough to admit a crow-quill.

In the trachea and bronchi down to the fourth division the fibrinous false membrane formed hollow cylinders, below this point solid plugs.

The lungs were œdematous, but contained no excess of blood.

The spleen presented the appearances characteristic of acute hyperplasia of that organ.

There was not sufficient evidence of cloudy swelling of the the other organs."

This is the entire history, as given by those having charge of the case from first to last; but even a casual glimpse of the patient's symptoms will demonstrate beyond a doubt, that it is but a very partial history, some of the most important symptoms having been *overlooked*.

This man's occupation, a brakesman on a railroad, was one that exposed him to extremes of temperature; one moment he was beside a red hot stove, the next, in the chilling gale of a New England September.

His earlier symptoms were, no doubt, similar to every one of this class of patients who complain of severe throat trouble. In every one of them they have evidence of nasal inflammation previous to their cough. He had epistaxis, the result of most excessive congestion, a congestion so great as to rupture the bloodvessels, and headache so severe as to affect the pneumogastric nerve to the extent of producing nausea. His cough dated back to September. As this cough was not caused by any pulmonary disease, we must look for its cause in a diseased condition of the nasal and pharyngo-nasal passages. The uniformity with which inflammation of these cavities give rise to a laryngeal irritation, compels us to say that their condition was the cause of the cough symptom. The cough would soon occasion sore throat, which in turn would produce an aphonia.

Of course, it might very naturally be expected that a severe diseased condition of the nasal passages and the throat, might cause sleeplessness, but we also know that the steam atomizer, applied for half an hour or an hour, repeated every two hours during an afternoon and an entire night, must have a very injurious effect in a throat that was so diseased that the patient had lost his voice, and must have helped in producing his restlessness during the night. The mucous membrane absorbed the water from the steam, thus thickening it and making it more ready to be injuriously affected; the inhalation of the atmosphere of the room, which, in comparison with the temperature of the steam, was quite cold. Thus the throat was subjected to such extremes of temperature—the heat from the steam and the cold air, after the withdrawal of the atomizer—that the inflammation was actually increased instead of being decreased.

In the post-mortem examination they *overlooked* another important matter; they neglected to extend their observations as high as they should have done. Their own history proves that they should have made a careful inspection of the pharyngo-nasal and nasal passages. Had this man had a hæmorrhage and a pain in any other part of the body, even if it had been on the foot, a most careful examination would have been made, and all the nerves that it was possible to have connected the two

parts together, would have been named. Why then should the pharyngo-nasal and nasal passages be slighted? Are they not intimately connected with the larynx, lungs, heart and stomach, by the pneumo-gastric nerve?

The following quotations are taken from an article contributed by Dr. Noguet, to the *Revue Mensuelle de Laryngologie, etc.*, June, 1882: "Enlargement of the tonsils is a frequent cause of deafness." If this expression had not been so frequently made, its erroneousness would not require contradiction and correction. Deafness always follows an extention of pharyngo-nasal inflammation up the Eustachian tube, when it prevents the normal entrance of air, or it may go still farther and affect the the middle ear. Pharyngo-nasal inflammation does not exist primarily, it is always a sequence of nasal inflammation. So also does enlarged tonsils follow as a sequence of pharyngo-nasal inflammation. In fact, this is to a certain extent, agreed to by Dr. Noguet, for he "recalls that naso-pharyngeal catarrh and chronic coryza, intensified by narrowness of the nasal fossæ, are often found in patients the subject of hypertrophied tonsils." Dr. Noquet goes on to say that "Hypertrophied tonsils favor the production of naso-pharyngeal catarrh, and in all cases excite and keep it up."

This is misplacing cause and consequence. The removal of hypertrophied tonsils will do much to relieve throat symptoms and some of the inflammation in the pharyngeal cavity, but will not cure a naso-pharyngeal catarrh, which is an extension of inflammation from the nasal cavities, the latter disease being caused by neglected colds.

"Tonsils which are much developed in an upward direction, or from before backwards, prevent tension of the velum palate, consequently, the muscles which open the orifice of the Eustachian tube can no longer act, and the means of keeping up a proper air tension within the tympanum, is lost."

I think it is exceedingly doubtful, that tonsils become so enlarged as to prevent the normal action of the tensor and levator palati muscles; but even if they did, neither of these muscles nor any other set of muscles have anything to do in keeping up a proper air tension within the middle ear. If the action of these muscles, in swallowing, gave the least opportunity for the air to enter the middle ear, then performing this act very frequently must have the effect of allowing a sufficient quantity

of air to enter the tympanum, to restore good hearing. And as patients remain continuously deaf even after very frequent acts of deglutition, this deafness proves that deglutition has nothing to do with air entrance into the middle ear. If the act of deglutition did do so, then we would have no use for the Politzer method of inflation, as the patients could be relieved of their deafness by more frequent swallowing than they do while in possession of normal hearing.

To the fact that the act of deglutition, apparently completely relieves the deafness and fullness in the ears, that are occasioned by their forcible inflation by one's own lungs, is due the maintainance of the Toynbee theory of air supply to the tympanum. That the act of deglutition does not completely relieve the deafness occasioned by the forcible inflation of the ear, may be proved by a very simple experiment.

First, find the exact normal hearing distance of the ear with a watch, note this distance; second, inflate the ears while the nostrils are closed, by forcing the air into them from the lungs. Immediately after this, perform the act of deglutition and instantly note the hearing distance from the watch. It will be found that this distance will be materially decreased instead of its being at the normal distance, as the illustrious Toynbee affirmed, but the normal hearing will return in a very short time, as the requisite amount of air will soon pass up the Eustachian tube, without any assistance.

Another experiment, which will prove conclusively that the air can be supplied to the middle ear *without* the aid of the act of deglutition, is the following:

First, find the normal hearing distance from the watch, note this; second, close the nostrils and perform the act of deglutition. This proceedure will abstract a great deal of air from the middle ear and occasion a fullness and a deafness. Now note the distance from the watch; it will be found to have been very materially decreased; refrain performing the act of deglutition for a few minutes, after the lapse of this brief time, it will be found that the normal hearing distance has returned, the air having entered the middle ear with the aid of any muscles.

It may be that the experimenter will be unable to resist performing the act of swallowing, and should he swallow, he will still find that the normal hearing distance has not completely returned, even after the act of deglutition, although this act will

relieve him of the apparant fullness and deafness. The normal hearing will not have completely returned even after several acts of swallowing, but in a short time, normal hearing will return without any effort on his part. I do not wish to be understood as saying that the excision of hypertrophied tonsils should not be resorted to in cases of deafness. I think that it is really a matter of necessity that they should be removed, but to expect that the deafness will be cured, simply by their removal, without the treatment of the nasal and pharyngo-nasal inflammation, is not logical, as the inflammation of these cavities precede all Eustachian and tympanic troubles.

Many surgeons excise enlarged tonsils at first sight. I prefer to treat the cavities above them, for one or two weeks, as they were inflamed, before the enlargement commenced. At the end of this course, that part of the enlargement that was due to swelling will have disappeared, and the part that was due to hypertrophy, will be seen and may then be excised, if it be thought best, but frequently the treatment proves that the enlarged tonsils were swollen ones only, and not true hypertrophy.

ARTICLE XXXVIII.

GONORRHŒAL ARTICULAR RHEUMATISM.* By E. A. CHANCELLOR, M. D., of St. Louis.

The subject which will claim your attention, is one almost ignored by the profession at large, possibly on account of the infrequency of such cases and the close similarity to other affections of a kindred nature. It is not the purport of this article to bring to light any new ideas nor to explore any untrodden ground, but simple to call attention to known facts which should be familiar to all; which in this grave complication, gives singular gravity to gonorrhœa, so generally looked upon as a simple and trivial affection. Much discussion has taken place in recent times as to whether such an affection as "gonorrhœa arthritis" really

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exists, and only at the end of last century (1781) did this subject gain credence, and then through the observations of Hunter, latterly Ricord, Fournier, Lorain and Rollet, who contributed the most to make the affection a distinct nosological entity.

To have this class of rheumatism we must have as an essential condition, the existence of gonorrhœa; but this does not suffice, "it is requisite in order to be affected, that the subject should have a special disposition, which is not as some have wished to establish, a certain tendency to the rheumatic diathesis."

The etiology of this affection appears to be an *ichoræmia*, or the absorption into the blood of morbid matter, effused into or formed upon the membrane of the urethra. This is theory and bare of demonstration. It is well known that females are seldom affected with this form of rheumatism, which some explain by citing the fact, that the vagina and not the urethra is the common seat of gonorohœa in women; yet we may assert that this is an articular affection, having a special connection with gonorrhœa, and not merely an attack of articular rheumatism, coinciding with the urethral lesion; we notice in those cases that cannot have gonorrhœa without immediately seeing one or more of their articulations become the seat of disease, that without gonorrhœa their joints are always perfectly free and not the subjects of after catching cold, bad hygiene, exposure, etc. to articular pains. It has not been my privilege to see cases of acute articular rheumatism occurring in subjects of gonorrhœa, without being able to say that the gonorrhœa has exerted on them a marked influence, and those cases do not pursue the course of ordinary acute rheumatism.

With your indulgence I cite a few cases taken at random from my case book.

CASE I.—James A. H., sailor, æt. 30, sanguine temperament, admitted to hospital on the 9th day of April, with an acute pain in the left knee, accompanied by swelling and considerable effusion. The pain together with the abnormal condition of joint, caused further investigation; and on examining patient's urethra, obvious signs of gonorrhœa were found, which he had been combating for seven weeks, and only a few days before entering hospital did the knee give him any trouble. His appetite had disappeared and his rest was much disturbed, yet with the above symptoms he had no pain, no perspiration nor any

abnormal condition of the urine. Patient was free from any tendency to a rheumatic diathesis, nor had he at any time previous to this attack, pains in any part of body, though he had been frequently exposed to the cold and wet. He was at once prescribed an urethral injection consisting of armeian bole and sulphate of zinc, which caused the gonorrhœal discharge soon to subside; but with the disappearance of the former, the articular rheumatism increased in severity. He was now confined to bed and kept in a horizontal position with the leg extended and somewhat elevated upon pillows; the knee was freely painted with cantharideal collodion and within seven hours a uniform blister of good size was drawn. With the free use of salicylic acid and lig: am: acetatis, patient experienced great relief, and in a few days he was up and about, the effusion having entirely left the knee to make its appearance in the tibio-tarsal and metatarsal articulations, the swelling increased, a blister was applied and as usual followed by great relief. The gonorrhœa had ceased before the disappearance of the effusion in the knee and the injection was discontinued; the patient was now directed a tonic which improved his appetite and produced an increase of nervous vigor.

On the 25th, of April the swelling and pain gradually left the ankle and foot, and showed itself in the right knee without redness or any febrile excitement, another blister was drawn with good result. Goulard's cerate (as in the above) proved an admirable dressing for the blistered surface.

On the 15th, of May patient was able to walk with a cane, free from pain and swelling, but yet complained of stiffness in the knee. Discharged on the 27th, of May apparently well.

CASE II.—Thomas B., a sailor, aged 25, of a weak and phlegmatic temperament, was admitted tohospital July 19th, with very obstinate gonorrhœa of two month's standing. Various remedies, external and internal had been tried without effect, and were it not for an existing phimosis with a balanitis he would have remained at home, for the discharge had now ceased to give him trouble. The patient was directed an injection consisting of tannin, carbolic acid, glycerine and water to be used four times daily, which was continued with gradual improvement until the 23rd, of August when the discharge ceased with the disappearance of the balanitis. Symptoms of indigestion now set in

giving rise to hypochrondriasis, palpitation of the heart, etc. These with other disturbances of the system soon succumbed to proper treatment; but not long (Sept. 10th,) had convalescence supervened ere an attack of intermittent fever (quotidian) caused patient to return to bed, where he remained for several days. This was readily controlled by the use of sulphate of cinchonidia. Further interest was now taken in the case, since on the 25th, of September the right knee began to give trouble by an immense effusion accompanied by pain and heat without redness. Blisters were applied freely to the joint and anodynes given to promote rest. A slight discharge was noticed on inspecting the urethra, for which sulphate of zinc, two grains to the ounce of water, was given as an injection. After three successive blisters to the knee the swelling partially subsided to reappear in the right ankle. This was treated likewise with blisters followed by an application of simple cerate. The swelling with the effusion continued to migrate, and it was next noticde in the left elbow, then in the left wrist and re-appeared again in the right knee. The patient gives no account of any tendency or disposition to rheumatism, the pulse was normal, no febrile excitement, free from perspiration and the digestive functions entirely natural. Discharged on the 6th, of November with an incomplete anchylosis of the right knee.

CASE III.—Samuel S., colored, aged 20, a professional tramp, entered hospital on November 8th, with pain and swelling of the right knee, which came on without any premonitory symptoms. About five days previous to the trouble in the joint he was cured of a long-standing gonorrhœa, which for a time was very mild, but increased in intensity a few days preceeding the pain in the joint. The patient can give no history of any previous trouble similar to this attack, having enjoyed excellent health up to the present time. The severest pain was experienced with the slightest motion and the knee was kept in a semi-flxed position, elevated upon pillows. Blisters were applied and morphia hypodermically given at night, salycilate of soda in ten grain doses every three to four hours was directed. The patient improved slowly on the above treatment and on the 14th, of November complained of intense pain in the right ankle with perceptible effusion. On the following day patient

was removed to Bayview hospital and hence subsequent history unknown.

CASE IV.—Edward F., colored, a teamster, aged 31, single; consulted me on Dec. 3rd, with pain and swelling in right knee and left ankle, for which he was prescribed iodide of kalium, wine of colchicum and salycilic acid, with this he slowly improved. On examining penis found a slight gonorrhœa of three week's standing, gave a popular urethral injection and the discharge ceased on the fourth day, however, the gonorrhœal arthritis grew worse until patient was confined to bed with knee elevated on pillows, twice blistered and afterwards dressed with simple cerate, and farther made comfortable by applying cotton and over this oil silk. On Jan. 15th, patient still kept within doors, with a slow but gradual improvement. The internal medication was now substituted for iodoform, Vallet's mass and bin iodide of mercury on which patient improved rapidly. There is no history of any syphilitic taint nor rheumatic diathesis, no rise of temperature nor heart complications, nor any abnormal condition of urine associated with the case.

With the disappearance of the effusion the gonorrhœa returned and received proper treatment, but very soon the left knee began to solicit attention by its pain and swelling; internal medication was renewed and blisters applied as above. Discharged on Feb. 17th, apparently well.

The signs and symptoms of gonorrhœal articular rheumatism are many and peculiar, coming on usually without any premonitory symptoms, *suddenly*, with very great heat and swelling, and the appearance of severe inflammation with the most excruciating pains; and localization in one or if several joints are affected, one of those (usually the knee) suffering with peculiar intensity, presenting an enormous effusion that may sometimes simulate a true hydrarthrosis; and may even lead to a spontaneous dislocation in consequence of the great amount of effusion, which unfortunately it is impossible to ascertain, as reported by some writers as occurring in the hip joint. One would naturally suppose from this abnormal condition of the joint so affected, that there would be an increase of *temperature* which is not the case, though in many subjects a slight febrile movement may last from two to three days—this is contrary to the usual routine of acute articular rheumatism. There is no appearance of erythy-

matous *redness* over the diseased joint so common in other forms of rheumatism, likewise the absence of *perspiration* is something quite noticeable.

The duration of gonorrhea articular rheumatism, is much longer than acute rheumatism, while the latter may last for fifteen to twenty days, the former will persist for two to three months and even four or five months in severe cases. There is much uncertainty about the influence which gonorrhea exerts on the intensity of the articular pains, which appear only at or about the fifteenth to the twentieth day, and then after the partial cessation of the discharge, though it is not rare to see the gonorrhœa arrested as soon as the "gonorrhœal arthritis" makes its appearance, to become aggravated again after the cure of the rheumatism, those cases are the most severe in which the discharge is scanty and thin, than those in which the discharge is the most abundant. Another characteristic of this special arthritis is the fact that it is not generally complicated, as in acute articular rheumatism, with cardiac affections. Having met with one case in the Baltimore Infirmary, May 1878, and a second in civil practice in the person of Philip F. a clerk, aged 22, of a nervous temperament; came under my charge May 2d, with pain and effusion of left knee, together with an acute sciatica. Patient at present was convalescing from a prolonged attack of gonorrhœa, but to facilitate the progress of the cure he was placed upon an urethral injection of sulphate of quinine, claret wine and glycerine, with happy success. Salicylate of soda with iodide of kalium were given in large and frequently repeated doses, which seemed for a time to aggravate the symptoms; a blister was now drawn on the already greatly swollen knee, which was dressed with vaseline and Goulard's ointment. Very soon pains in the shoulder were manifest, which were finally located in the sterno-clavicular articulation, with no febrile excitement, nor redness, nor perspiration, yet a slight discharge which increased somewhat since the disappearance of the effusion in the knee. Repeated examinations were made of the urine, but no abnormal condition was present. It was now the 10th, of June when these symptoms supervened, and not long ere the patient complained of difficult breathing (dyspnœa) accompanied by palpitation and irregular action of the heart with all the symytoms of endocarditis. The patient was put on proper treatment but did not rally as speedily as we had hoped, a consultation confirmed the diagnosis and the case was placed in

hands of a brother practitioner and lingered for some days. It was now the eve of my departure, hence, subsequent history not known, nor the result of the autopsy. * * * *

Dr. J. Marty (*Arch. Gen. and Schmidt Jahrb.*) has encountered a number of cases of endocarditis existing simultaneously with gonorrhœal rheumatism and I take the libererty of citing some of the most important of the author's conclusions:

(*a*) Gonorrhea may be, and often is, complicated with inflammatory affections of the serous membrane.

(*b*) Rheumatism is not always the connecting link between the specific affection and the disease of the serous membrane, although these complications are quite frequently found to be simultaneous.

(*c*) True primary heart complications are rather rare. The point of origin is usually the orifice of the aorta.

(*d*) This specific endocarditis appears to present the same symptoms and danger as does the simple variety.

(*e*) The endocardium appears to be involved as often, in fact oftener than the pericardium.

"Gonorrhœa articular rheumatism seems to have a marked predilection for the large articulations and notably the knee, falling in order of frequency are the articulations of the wrist, the foot the shoulder, sterno-clavicular, the fingers and the toes, and the tarsal and the metatarsal."

My observations embrace a large number of cases of gonorrhœal articular rheumatism, yet I do not feel warranted in terming this form of rheumatitm other than poly-articular, so rare have been the cases in which one joint alone became affected that I did not deem them of sufficient importance to register. Suffice it to say, that when a single joint becomes the seat of trouble, it is usually acute, whereas chronic in the poly-articular variety. Not alone do we have a "peculiar arthritis" accompanying gonorrhea, but often thecitis and bursitis as in the sheath of tendons of the foot or wrist, or it may be in the tendo-achilles (bursa) or the tendons of the patella. Fournier believes that the pain sometimes ascribed to this affection of a bursa or tendon may be due to a deep seated periostitis—the pain under the heal for example.

The urine does not show any alterations that characterize ordinary cases of rheumatism, in fact no perceptible change from

its normal condition, save in some case more frequent micturation which is due to the local irritation and an occasional cystitis; though in some cases traces of albumen may be detected leading us to suspect "nephritis" which results from the propagation to the kidney of the inflammation that is seated in the urethra. The prognosis in cases of acute rhematism is quite favorable, usually resulting in resolution, leaving no traces of its presence in the joints, while the latter often ends in destruction of the articular cartilages, deformity of the limb and anchylosis.

No treatment has as yet met with success at the hands of the profession, being a local trouble we should naturally employ those agents which have a local action, such as counter-irritants, rubefacients, leeches, blisters, etc. Rest should be strictly enjoined upon the patient for a time and the limb kept in a good position, though flexion (by no means favorable) is instinctively adopted by patients and seems to mitigate the pain. With anodynes and especially morphia hypodermically, we may alleviate much suffering. The remedies with which we usually combat in ordinary rheumatism fail totally in gonorrhœal articular rheumatism, with the exception of iodide of kalium and salicylate of soda which have many advocates and justly so, for in many cases prompt relief usually results. Iodide of kalium and iodoform seem to have special action on chronic forms of the disease. Jabarandi has been tried with moderate success. In the main we resort to those remedies which are usually employed in the treatment of articular troubles. I have presented one of the many complication of gonorrhea, but fortunate for the masses one out of thirty or forty fall victims to this peculiar trouble.

It has frequently occurred to me and with some degree of plausibility, that there must be a duality of gonorrheal virus.

Article XXXIX.

Address of the President of the St. Louis Medical Society.

Gentlemen—

I thank you for the honor conferred in selecting me to preside over your meetings during the ensuing year.

Would that the place were as highly honored by the man as the man is honored by the place.

To fill the position that the great and good have adorned, and that has been distinguished by the occupancy of Beaumont, of Pope and of Hodgen, awakens a sense of unworthiness that mars the pleasure of the installation, by reminding me of how little I have done to deserve it.

I shall, however, seek to merit approbation by using my best energies to promote all of the interests of the Society, and if its work fails to be beneficial in their proper sphere it shall not be my fault. I trust the members apprehend how fatal to any effort their officers put forth, will be lethargy on the part of the members themselves. Let me therefore beg that each one will contribute his quota, towards maintaining interest in our discussions, and that each one will seek to advance the welfare of the organization, that membership may be coveted.

An earnest, enthusiastic, unselfish movement, in this Society single in its purpose to do the greatest good, is the only resource we possess to uphold the honor and interest of the profession in this city.

Other societies have been already formed and still others may be, and they subserve the special object that suggested their organization; but they are not, and cannot be substitutes for this one. We have little interest in other societies; but all others are interested in us; because this is, and must ever remain the representative professional organization of the city. The age of this body, its tradition, and democratic character, insures this result. It is the society of the whole profession, not of any clique or class; but of all respectable physicians, no matter what may be their personal or professional affiliations.

Any honor that is paid to the St. Louis Medical Society, belongs to the whole profession, and any disgrace that stains it touches in some degree, the fair fame of the profession of St. Louis.

The relationship of the profession to the Society cannot, I think, be properly regarded in any other light than that in which I have presented it, and I sincerely hope that animated by this spirit, every man who has the well-being of his profession at heart, will take a hand in the proceedings, and not attempt to solace indifference, with the thought that he has no responsibility.

If this idea prevails, I am certain that the cause of Science, and that of the local professional interests will be benefitted, and that personal intercourse will be more intimate and agreeable.

I thank you again, gentlemen, for the honor conferred upon me.

Proceedings of Medical Societies.

Article XL.

ST. LOUIS MEDICAL SOCIETY.

Taken by the Journal's Stenographic Reporter.

Saturday, Feb. 10, 1883.

Dr. Bernays.—I have a couple of cases here of plastic operation, which I would like to have the members look at for a few minutes. The first is a case of cancer which involved the jaw and part of the mouth, the lower lip; the other is a case that involved the back of the nose, up as far as the frontal cavities, the whole nasal bone and the whole of one side of the lachrymal bone. I removed the cancers in both cases, performing plastic operations. This is the patient who had the cancer on the lip. I performed the operation about five or six months ago. The other was a case of carcinoma that started on the back of the nose, between the eyes, and it grew gradually until there was a lumpy tumor there which ulcerated about the middle space between the nasal bones, and began to encroach upon the frontal. I was obliged to insert a saw into the side of the nose, and by sawing through the bones that came in my way, I cut down through the frontal bones and also through the lachrymal bone, then with the knife I removed all this part of the nose, making a straight cut across its back. This left such a very large defect that I was obliged to cut a flap out of the forehead which reached almost to the hair, the beginning of the growth of hair, the flap healing by first intention. Since then the nose has fallen in, there being nothing left to hold it up. You will find that the point of the nose is normal, but the back of the nose has sunken in. However, you will find no ulceration and no suppuration; not the least bit anywhere. The only disagreeable point about this case, is the lack of the lower eyelid, which I was obliged to cut away in part, the lower eyelid of the right eye. The scar on the forehead has become very smooth; it is very noticable, and there has been no return of the disease so far.

I think the woman may be congratulated on the success of the operation, so far as the removal of the cancer is concerned. It has certainly not improved her looks any, however.

Dr. Williams.—I would like to say a word in regard to the last case. I would suggest to the Doctor that instead of making an additional plastic operation, which I believe he proposes to do, I would simply enucleate the lachrymal gland and stop the flow of tears. The greatest trouble with the lady is the constant lachrymation—the tears running down over the face, excoriates the skin. It is an easy matter to relieve her of that trouble by enucleating the lachrymal gland of the eye. If I were in his place I would do that instead of trying an additional plastic operation.

Dr. Hurt.—I would like to ask Dr. Williams what effect the destruction of the lachrymal gland would have upon the mucous lining of the conjunctiva of the eye?

Dr. Williams.—It has no perceptible effect whatever; certainly no bad effect.

Dr. Meisenbach presented a pathological specimen of glio-sarcoma, and read a paper on that subject. (Which appears in the Original Articles.)

Dr. Post.—The case presented by Dr. Meisenbach, with the accompanying specimen is of very great interest. It represents a class of cases which is one of the most important contributors to our study of malignant growths. It is also of interest because it represents a class of cases which any practitioner is liable to meet with; they come into the hands of the general practitioner first, and are afterwards brought to the specialist and his proper diagnosis and treatment may result in the acquisition of additional exact medical knowledge, and in alleviating the suffering or possibility in saving the life of the patient. This case is of special interest to me, inasmuch as I had an opportunity of seeing the patient during life, through the courtesy of Dr. Meisenbach. I advised the parents of the patientto have the eye enucleated immediately. If this advice had been followed, it is probable that the life of the patient would have been prolonged, though probably the disease would have returned. This tumor has been examined quite carefully and the microscope discloses the fact that it is a glioma or a glio-sarcoma of the retina.

The histological position of glioma of the retina is not positively determined. You will recollect that the retina is divided into various layers; enumerating from within outwards, we have the internal lining membrane, the nerve fibre layer, the ganglion layer, the molecular layer, the internal granular layer, the inter-granular layer—the external granular layer, the external limiting membrane and the layer of rods and cones. By some histologists, retinal glioma is described as a proliferation of the retinal granules, *i. e.*, a proliferation originating in one of the granular layers. It is held again, by Rindfleisch and some others, that glioma of the retina is a proliferation of the cells of the neuroglia. Delafield, of New York, in a report upon glioma, read before the American Ophthalmological Society, in 1870, describes glioma as arising from the connective tissue cell of the neuroglia, and as the connective tissue cell is characteristic of sarcoma, he classifies these tumors as glio-sarcomata. I think there is a tendency at the present day, among oculists and histologists, to adopt the same classification. The objection may be made, that sarcomata are often removed and do not return. Why is it then if glioma of the retina is of the same nature, it is so much more fatal in its results than choroidal sarcoma? The answer is found in the anatomical relations of the tissues invaded. The sarcoma, or as we ordinarily call it, choroidal sarcoma, originates in the choroid which is enclosed by the unyielding sclera and terminates at the optic foramen, so that the disease may exist for a long time and not spread beyond the tissue in which it originated. There are many cases where the patient has lived many years after the removal of such tumors, and died of some other disease. On the other hand, the tumor which we call retinal glioma, originates in the retina, which histologically is an expansion of the optic nerve and in direct communication with the brain. Another reason of great importance why retinal gliomata are so much more fatal than choroidal sarcomata, is that glioma of the retina is a disease of early childhood and infancy. It occurs in patients who do not recognize the fact that there is a loss of vision; or if they recognize it, are not capable of attraction attention to it; and it goes undetected till it has reached such proportions that it is observed by others? Then although we may remove it from the site of the original invasion, we are unable to reach the ramifications of the disease, and the fatal result ensues sooner or later. The disease is one of child-

hood and infancy. You may say it is the malignant growth of infancy. Sarcoma has been found in children. There is one case in which a sarcoma was found in a child three years of age, and there are other cases reported. Glioma has been stated to have have occurred in adults. I have the report of a case in mind, of a patient some 23 or 24 years old; but it certainly is rare, so that we are justified in regarding the disease as one of childhood. Knapp, in his book on intra-ocular tumors, describes seven cases of gliomata. These seven cases were all under the age of five years. Delafield, in the article to which I have referred, gives an account of five cases, all of which occurred in children under five years of age. Carter records five cases in his book published in 1875; of these, in two, he does not give the age, but from the context we are justitified in assuming that they occurred in young children; the others were in children under four years—one was three years, and one two years; the other was some four or five months old. During the last eighteen months, three cases have come under my observation. One was a child six years old, another five years, another nineteen months.

It is of the utmost importance for us to be well posted upon this disease clinically. There are certain things with which it is liable to be confounded. If we find something growing in the eye of a child, back of the lens, occupying the vitreous chamber, we should ask ourselves whether it is glioma or not. There are certain things which belong to the diagnosis of glioma of the retina, which come only by experience, which belong to the medical sense, you may say. Such is the old characteristic feature, the metallic yellowish brilliant lustre which comes from the eye, which has given it the name of amaurotic cat's eye. The conditions with which we are most likely to confound this disease, are choroidal sarcoma, and choroidal exudations. As choroidal sarcoma is a malignant disease and the treatment is immediate removal of the globe, mistaking choroidal sarcoma for glioma would lead to no bad results. With regard to choroidal exudation, we must depend largely upon the history of the case. There are certain antecedents which would incline us to the opinion that it is a choroidal exudation rather than retinal glioma that we have to deal with. Choroidal exudations follow upon choroiditis; we also find them following some injury to the eye, as where a foreign body has been lodged in the eye; we frequently find then following cerebro-spinal meningitis. It

has been my experience to see a number of these cases. I have seen two or three cases where the statement has been made to me, that the disease preceding the trouble was typhoid fever. My knowledge of the correctness of the diagnosis did not permit basing any conclusion upon the statement. It would seem quite possible that we should have some such trouble following typhoid fever; we have abscesses after it, and suppurative troubles, and it does not seem to me improbable that the choroid might be invaded in a similar manner.

The prognosis in retinal glioma is most unfavorable. Knapp, in his seven cases which I have beforespoken of, records the death of five of them, and it is certainly implied in the other two, for he makes this statement, that "in well established cases the results have been, probably without exception of a fatal character." Delafield, in his cases, records the death of four out of the five. The fifth, he states, was living at the time it was last seen—this was fourteen months after the removal of the original tumor. There was no return of the tumor. Carter has recorded two cases of recovery, one of them is the case of a child, where the tumor was removed and was seen four months after with no recurrence. That I should not think was sufficient length of time to establishlish a case of recovery. There is, however, another case in which he removed a tumor from a child three years of age, who at the time of writing, was fifteen or sixteen years old, and there was no recurrence. We would probably be justified it putting that down as a case of recovery. Sichel reports a case of spontaneous recovery, where the disease was treated by his method, which I suppose might be called an "alterative treatment." Atrophy of the globe occurred and recovery resulted. In the cases which I have seen, death has resulted in all. On the 4th of August, 1881, I removed an eye containing a retinal glioma. The child, at the time, was very much emaciated and was suffering a great deal, was a very sick child. Immediately upon the removal of the tumor he began to improve, and it was hoped that the disease would not return. Four months later the tumor reappeared in the orbit, but the child continued in good health and free from pain till April 23rd, 1882, about eight and a half months after the enucleation, when the tumor became very painful and in three days the child died very suddenly. I saw him only once and there was no post-mortem. The ordinary course for glioma

is for some such result as Dr. Meisenbach has reported to-night, to occur. The globe ruptures, a discharge ensues and the patient dies from exhaustion. The parents of Dr. Meisenbach's patient told me that the child's eye had been as it was when I saw it, five or six times before. This is often the case. The tumor recedes and comes again and frequently the parents encourage themselves with the idea that the disease has disappeared, when in fact it is only quiescent for a short time. With regard to the treatment, my own opinion certainly is that as soon as the diagnosis has been made, as soon as we are sure or have good reason to suppose that the child has glioma of the retina, we should enucleate and remove as much of the nerve as possible, and I am inclined to think that in such case there is a prospect of permanently curing the case. My opinion is based upon this case of Carter's and upon one of the cases that Knapp reports in which he says that one eye was removed and the other eye was invaded by the disease sometime afterwards. The other eye was not removed and the child died. At the post-mortem, the optic nerve of the eye which had been enucleated, was found to be in a normal condition, indicating apparently, that if the glioma had been removed from the other eye, the disease would probably never have manifested itself again.

Dr. Pollak.—You may add two more cases to those who have recovered from glioma after enucleation. One case in which I enucleated the eye of the patient, some twelve years ago; I enucleated the eye for a very typical case. One-half of the eye I sent to Dr. Knapp, at New York, and the other half I have myself. I had it mounted for the microscope by Dr. Baumgarten. This operation was performed twelve years ago and there has been no recurrence of the disease. The other eye is perfectly sound. The other case is one which Dr. Dickinson will probably remember; it was operated on, eighteen or nineteen months ago, a boy ten years old. This was also a very decided case of glioma. I saw the parents of this child only a few days ago and they told me the child was perfectly well, at least there was no recurrence of glioma. All the other cases of this disease which have come under my observation, have been inclined or subject to secondary tumors and death has always been the result.

DR. POST.—I would like to ask the Doctor the age of the patient whom he operated on twelve years ago?

DR. POLLAK.—I suppose she was 38 years of age; she is now 50 years old.

DR. DICKINSON.—I have seen several cases of this kind. The longest period that any one has survived the operation, according to my observation, was fifteen months.

DR. POLLAK.—I would like to ask Dr. Post if he ever saw a case of double glioma, in which both eyes were affected?

DR. POST.—The case which I referred to is a child nineteen months old, was one in which the eye was removed and the glioma reappeared in the other eye in about two months. The other eye was not removed so far as I know, and the patient died.

DR. POLLAK.—I don't refer to that kind of cases. I mean cases in which both eyes were affected at one and the same time—simultaneously. About two months ago Dr. Fairbrother showed me a case only two months old in which there was typical case of glioma in both eyes—there was the metallic luster in both eyes.

DR. POST.—I see no violation of any law in that. I should think it would be natural enough for that to occur.

DR. WILLIAMS.—While we are on this subject I wish to say that I have seen several cases of this kind of giloma of the retina, and so far as my memory serves me now they have all died. I remember one boy about five years old at Cincinnati who had double giloma, both eyes were simultaneously affected. The parents of this boy, because I couldn't promise him a restoration of vision would not submit to operation at all. Of course the boy died. I have a lady patient in the city just now whom I suspected of having glioma in the beginning but I think it is not. I think it is a tubercular deposit in the eye, although I felt quite sure it was glioma when I first saw her.

Dr. Chancellor then read a paper on "Gonorrhœal Orchitis." (Which appears as Original Article.)

DR. LOVE.—This is a very interesting subject—exceedingly interesting to me for the reason that recently I had a very interesting case of gonorrhœal rheumatism which affected the knee joint. The suffering was intense and it came on during the progress of a case of gonorrhœa which I had not previously seen.

As soon as the rheumatism occurred the gonorrhœal discharge ceased. My treatment was active. I blistered, I rested, I gave salicylic acid internally; I gave iodide of potassium, anodynes etc. but the case progressed unfavorably both to me and to the patient. Day after day there was no marked change; his suffering was very great, and greater at night, and I was finally forced to allow him to place the leg in the flexed position, which seemed the most comfortable to the patient. After blistering and applying an emollient to the blistered surface, I applied a certain amount of pressure, hoping that the pressure might produce comfort as it does sometimes in cases of effusions in joints. I was finally obliged to place the limb in a Hodgen splint—the inclined splint. This gave him comfort as he could move his leg around and sit up. It gave him more comfort than anything else, but it looked formidable and made him feel that the case was serious to have it strung up to the ceiling; it disturbed him and after a few days I was informed that my services were no longer required. He had gone back to his first love—little pills and homœopathy. I learned the next day that the case had taken a sudden turn for the better. I suppose sufficient time had elapsed for my active medication to take effect. The homœopathic physician who attended him is a friend of mine, and he is the only man in St. Louis who really confines himself to infinitessimal doses, and who believes "similia similibus curantur" is the true and correct law; and that medicines increased in strength as they were diluted. Well, I met him and wanted to know his treatment, for I have always been liberal enough to take ideas from even a homeopathic practitioner. He told me that he had given the man pulsatilla I forget the strength of the dose, but it was of exceeding smallness. I didn't receive any satisfaction from him, but I was still further confirmed in my opinion that the patient had got rest, and my medicine had had time to take effect. The subject is exceedingly interesting to me and I would like to hear further remarks about it. In this connection I would say that I believe that the indication for treatment is the same, and the same course should be followed as in a case of gonorrhœa. We should produce a free flow of urine; give citrate of potash, carbonate of lithiria. These I believe most excellent in an acute case of gonorrhœa. I think an acute case can be treated very efficiently by giving these remedies. We should act upon the kidneys and produce a large flow of urine. I remember a remark made by Dr. Hodgen, which was

to the effect that he believed in the treatment of gonorrhœa the principle to be followed was not to give medecine at the wrong end; not to drive anything into the urethra or into the bladder, but to make the kidneys act and wash the poison out.

DR. HUGHES.—The question comes up however, is there such a thing as a distinct gonorrhœal rheumatism; have we any facts which indubitably establish the existence of a distinct species of rheumatism of this character. Have we any more gonorrhœal rheumatism than we have malarial rheumatism? We have rheumatism superinduced by malaria as its excting cause; we have rheumatisn brought on by gonorrhœa as its exciting cause; by the depressing emissions and prolonged strains upon the organism—strains which depress vitality and permit the latent diathetic condition to express itself in a localized rheumatic inflammation. But we cannot erect them into a species any more than gonorrhœal rheumatism can be so erected. Now you will observe in these cases that an individual who is inclined to have rheumatism, if he contracts the gonorrhea and it produces an irritation and depression of his system, you will find him suffering from rheumatism, rheumatic arthritis as a concomitant, but is it the sole consequence of the specific gonorrhœal inflammation? I have grave doubts upon that subject. I do not believe the clinical facts are sufficient to justify the conclusion that there is such a thing as a specific gonorrhœal rheumatism independent of the constitutional diathesis. The individual who has rheumatism accompanying gonorrhœa at one time will have a recurrence of the rheumatic inflammation upon becoming depressed in consequence of malarial empoisonment, and the next physician who is called to treat him characterizes the disease as malarial rheumatism. When a man speaks of malarial rheumatism I understand that he means rheumatism which is present, malaria which developes a latent condition. It is not uncommon to find an individual who is disposed to rheumatism have it in consequence of some depressing cause. It is only necessary in these cases to have a source of constitutional irritation to depress the system in order to bring out the latent diathetic condition, whatever may be the exciting cause at the time is likely to be called the specific cause —the especial cause—the sole cause whereas it is but the determining factor, and the all important factor is the underlying diathetic condition; it is because the individual has a rheumatism

in his constitution and becoming depressed in consequence of the gonorrhœal empoisonment he develops a latent diathetic condition. It is hardly sound to conclude that because gonorrhœal rheumatism is often somewhat different in its appearance from other forms of rheumatism it is different in its effects. There are shades and degrees of the rheumatic inflammation in the same person at different times of his life, and in different persons.

Dr. Prewitt.—It has been very seriously doubted whether there is any such a thing as gonorrhœal rheumatism. I think we may express quite a strong doubt. For my part I have doubts as to the existence of gonorrhœal or malarial rheumatism. I have no doubt that there is a synovitis occurring in conjunction with gonorrhea, but I don't believe it to be rheumatism. Rheumatism is due to a specific cause just as much as small-pox or measles.

Where there is a synovitis—that which occurs with gonorrhœa—it is not due to the same cause as rheumatism. It will not do to say that it is simply the development of a diathetic condition. I think for the reason that we find these cases of so-called gonorrhœal rheumatism being manifested in patients who have no rheumatic tendency, who have never had rheumatism, except when they had gonorrhea. I remember to have treated a case of a man who was subject to gonorrhœa—had a gonorrhœal diathesis; and every time he had gonorrhea he had this rheumatism that is, he had swelling of the knee joint, and at no other time. In my experience the trouble has been limited to the knee joint. This trouble is not due to the same cause as rheumatism; that is very clear to my mind, it is not, strictly speaking, a rheumatism any more than acute synovitis is a rheumatism. There is no relation between the so-called gonorrhœal rheumatism and true rheumatism any more than there is between acute synovitis and rheumatism. It is not amenable to the same treatment. It seems to me that it is wrong to speak of it as rheumatism because it conveys a wrong idea.

Dr. Hughes.—Do we not find that patients who have gonorrhœa manifest rheumatic symptoms sometimes?

Dr. Prewitt.—There is no question that a man may have gonorrhœa and rheumatism at the same time; but it does not follow that one is dependent on the other. We are speaking of an affection of the joint which is dependent on gonorrhœa. I don't believe it is rheumatism. I don't believe there is such a thing as

malarial rheumatism or gonorrhœal rheumatism which results from a depression of the system. I believe it is due to a specific cause just as I do not believe small-pox is due to malaria, but to small-pox poison.

SATURDAY, Feb. 17, 1883.

DR. LAIDLEY.—I have a specimen to present to the society. Five years ago I circumcised a gentleman for a troublesome phimosis which permitted only a small quantity of water to be passed at a time, and by this means I remedied the trouble under which he was laboring at the time. About a month ago I was called to see this patient on account of a tumor that was located near the head of the penis, underneath it, and extending along and reaching within an inch of the lower margin of the meatus urinaris, extending back a distance probably in its greatest diameter of three-quarters of an inch. This tumor extended downwards and forwards at an angle of about 35 degrees. On examination I found what I thought to be a horny tumor. This specimen which I have with me shows the character of the tumor. After it was removed I endeavored to remove not only the tumor but the membranes which produced it, and in so doing I cut as deep as was possible without cutting into the urethra. Subsequent examination showed that I did not cut deep enough to secure the membrane from which it was developed, and the result of the operation is that it was a failure. On day before yesterday I learned that the tumor was being reformed. I would like to have the members examine this tumor. It is rather peculiar as appearing on this organ, and especially in that part. On looking up the history of these operations I found that these tumors are not very frequent on that part of the body, and but very few of them are recorded as having occurred on the penis. Another point of interest in this case is the fact that the tumor has attained its present size in a very short time. While I have the floor I shall present the splint which was used in the case of resection of the knee joint which I presented two weeks ago. I present it because of its simplicity and the good results which it secured. It is as simple as it could be made. It is composed of two parallel bars of iron passing on two sides of the leg, secured by bandages and plaster-of-Paris so

as to hold the limb in position. The fenestræ enabled me to apply the dressings without removing the splints. The splints after being applied were encased in plaster-of-Paris bandages passed across from one side to the other.

Dr. Johnston.—I think these tumors designated under the head of horny tumors are growths of the dermoid tissue, they originate perhaps in some of the sweat glands—the sebaceous glands. We know the nature of these tumors is very much the same as hoof and horns or the nail of the horse, and they are sometimes found growing from the mucous tissue; but I think if we examine the subject carefully we will find that they are mostly confined to the true skin—the epidermis, and they are in their nature and substance made up of the same material as the finger nails. They are the same in structure as the horny tumor which we have all seen growing on the fore-leg of the horse. They are supposed to originate through some iritation.

Dr. Hughes.—I want to ask Dr. Laidley what is the advantage of a resection of the knee joint over an amputation?

Dr. Laidley.—I am sorry that the patient is not here to-night for I could demonstrate the advantages. Dr. Johntson asked the same question the other night, though it was based upon a different statement; it was based on the statement of a a case in which Dr. Lutz operated where there was four inches of shortening, which was of course a good deal of shortening. If my patient was here he would show a leg in which there is only one inch or not exceeding an inch and a quarter of shortening, and you would see a limb that he can use without difficulty after four and a half month's time. It is certainly a very useful limb. Before the operation the man suffered intense pain, and he was continually falling and fracturing the adhesions, and during this time he suffered from continuous fever; this operation has relieved him of all these troubles and allowed him to retain his limb, which is certainly very useful. It is perfectly straight and only about an inch and a quarter shortened. He walks without any difficulty. No one to see this man walk would know that an operation had been performed, except for the stiffness of the joint; of course he has no use of the joint, but otnerwise the limb is in as good condition as it was before it was injured. There is no doubt that this leg is better than a cork leg. An amputation would endanger his life as much as a resec-

tion, and as a result we have a very useful limb. It is certainly a very satisfactory result to the patient.

DR. HUGHES.—That is all I want to know. I don't see any advantage of this stiff leg with some shortening over an artificial one without shortening. I think if it were my leg I would prefer to have it cut off than to have such a leg.

DR. DICKINSON.—It is pertinent to this subject for me to state that it was my pleasure to see a similar operation to this performed by a surgeon in London. He performed it in this case because the knee was bent nearly at right angles—90 degrees—and a fragment of the bone was removed so as to straighten the limb. What the result was I don't know. While at Charing Cross Hospital Mr. Guthrie called my attention to a patient in which he performed an operation in a similar manner exsecting a right angle of bone.

DR. CHANCELLOR.—In presenting the subject of gonorrhœal articular rheumatism at the last meeting, I did so from a practical and not a theoretical standpoint; my observation extending over several years at hospitals in Baltimore, Philadelphia and New York together with many years in civil practice. I did not claim for this subject that it was an entirely new one to the profession; but there are many points which are different and distinct from the ordinary articular rheumatism, arthritis, pyarthrosis, ryperplostic arthritis, etc. It differs in many respects. You have no febrile excitement, you have no perspiration, no elevation of the pulse, and it is not dependent upon any rheumatic diathesis. The effusion or swelling coming on with the cessation of the discharge of the gonorrhœa and reappearing as soon as the effusion of the arthritis disappears. And then in these cases of gonorrhœal arthritis we find that they are always chronic and not like the ordinary rheumatism, which is acute or sub-acute and very seldom chronic. Then again the ordinary rheumatism tends to resolution whereas this does not; so also gonorrhœal articular rheumatism produces anchylosis complete or incomplete. At the last meeting I failed to call attention to many remedies that I have used in the treatment of gonorrhœal articular rheumatism such as cupping and leeching, the lateness of the hour not permitting me to do so. I also neglected to speak of the benefits to be derived from the thermo mineral waters, saline and alkaline with which to my knowledge Dr. Jourdan has

experimented considerably. I would like to have the subject discussed further by the society, not wishing to say anything further until I hear the views of the members on my paper. A point was raised last Saturday as to whether this trouble ever occurred anywhere besides the knee; I can state that I have seen some thirty-three cases which have all been poly-articular and not mono-articular. Dr. Love reported a case in which it was mono-articular. I did not record such cases because I thought they were of so slight importance as not to require notice.

Dr. Atwood,—I would like to ask the doctor whether he has ever seen as a result of gonorrhœa an effusion start on a serous surface elsewhere than in the neighborhood of a joint?

Dr. Chancellor.—No, sir; but I have seen cases of peritonitis resulting from gonorrhœa; also an inflammtion of the duct of the gland of Duverney.

Dr. Atwood.—I have had some experience in the treatment of gonorrhœal rheumatism, and recognize it as a distinct disease. I do not believe the name is a mis-nomen. I take precisely the same view that has been expressed by Dr. Chancellor and the question that I asked him was pertinent to a case that came under my care some years ago. I think the case is well worth recital, and I felt certain that it was a case of gonorrhœal rheumatism. I took charge of the case some two months after the incipiency of the attack; in the meantime he had been under the control of another physician but there had been no improvement and when I saw the case the man was lying in bed where he had been for that length of time and was somewhat neglected by his nurse. He had several large bed sores. The history of the case previous to this time was about this: While laboring under an attack of gonorrhœa he was suddenly attacked with violent pain at the occipito-cervical junction and immediately began to suffer from what appeared to be hemiplegia. The pain he described as most excruciating, exceedingly decided and permanent. When I saw the man there was complete paralysis. The joints—the elbow, wrist, knee and ankle were as I say enormously enlarged, and they were œdematous. There was evidently an effusion. It was easy enough to detect the chronic thickening of the tissues adjacent thereto. Well, in the course of my inquiries I observed the fact that he had gonorrhœa and I

believed that the desease was dependent upon the primary malady. I treated him not with plasters but with the application of exceedingly strong liniments. I gave him mercury, strychnine and quinine; and had the parts rubbed with veratrum, oil of mustard, etc. and also had it placed on cotton and applied to the parts and wrapped with oiled silk and suceeeded after a time in procuring a diminution of the swelling and the paralysis disappeared; but the gonorrhœa had returned. I am satisfied that this effusion of the membranes was the result of the gonorrhœa.

DR. GREEN.—I would like to inquire if in these cases of peritonitis the patients get well?

DR. CHANCELLOR.—One case in three died. Two of the cases were in Baltimore and one in Philadelphia.

DR. GREEN.—Was it general peritonitis or was it peri-metritis?

DR. CHANCELLOR.—It is peri-metritis, usually.

DR. JOHNSTON.—I don't think the doctor stated whether in these thirty-three cases there was any examination of the urine to see whether there was any uric acid present.

DR. CHANCELLOR.—Yes, sir; I stated that the urine was examined and that none was found in the majority of cases.

DR. JOHNSTON.—I should think then if there was no uric acid present and the analysis of the urine was carried on correctly—scientifically—then it would follow that we would have to exclude the theory of a rheumatic diathesis in these gonorrhœal cases; and then the question comes up, by what process does the cessation of the discharge at the head of the penis cause the disturbance of these other parts. Is the discharge absorbed by the blood in the neighborhood of the joints so that you have an acute synovitis or a disturbance of the intestines?

DR. HUGHES.—I want to ask Dr. Atwood in regard to this case that he has reported, in which there was hemiplegia, whether he would regard the hemiplegia as gonorrhœal hemiphlegia. I am sure that he would not. I am sure that the nomenclature would not justify the application of that term. I wish to be understood as not having denied the clinical facts set forth in the excellent paper of Dr. Chancellor last Saturday evening, but as

controverting only the view that there is such a thing as a specific gonorrhœal rheumatism independent of a rheumatic diathesis. Now in the detail of the doctor's cases he gave us the treatment which consisted of salicylic acid frequently administered and I have no doubt that the treatment was correct; and I have no doubt that those of them who displayed rheumatism, possessed the rheumatic diathesis and would have had rheumatism if some other equally depressing influence had been acting upon the vitality of the system. It cannot be explained upon the hypothesis of septic infection and arthritic implication which sometimes follows gonorrhœa, because the septic infection takes place too rapidly and when it assumes the character of rheumatism the inflamation disappears too suddenly so that I cannot concur with the expression of Dr. Prewitt that it was the result of a septic infection. I believe in the existence of a rheumatic condition that may be excited by gonorrhœa as an exciting cause superimposed upon a rheumatic diathesis. That is all in my opinion that there is in it. Gentlemen who meet these cases clinically recognize the fact in the treatment in the majority of them· It is revealed where you have a general rheumatic fever; it is revealed where you have the existence of lactic acid. The only objection that I wish to make to the excellent paper is the giving of a specific name to this trouble.

Dr. Hurt.—I am not aware that anyone present—not even Dr. Chancellor—contends for the genuineness of the rheumatic nature of this trouble although it is a synovitis, an arthritis or a peritonitis and when a synovitis it is called rheumatism because it is a disease analogous in its location and symptoms to that of rheumatism; and it is believed that it has its origin in a retrocession of the gonorrhœal virus or irritation. Now, I don't know that any authority has undertaken to contend that it is a rheumatism derived either from a rheumatic diathesis or from any other cause such as acid or lithates in the blood such as we find in true rheumatism; simply it is called gonorrhœal rheumatism for the reason that we have a disease that resembles rheumatism; just as we have a disease that resembles measles which we call German measles. That is for the same reason. Custom makes law. Custom gives names in medicine. When we come to study the pathology and causation of it, why, of course, we go to the

cause. For that reason we call it gonorrhœal rheumatism, or gonorrhœal penitonitis. I think one of the most violent cases of gonoerhœal puerperal peritonitis that I ever saw was a gonorrhœal peritonitis, and I think it was a general peritonitis. The patient before the disease terminated in convalescenee was enormously swollen; as much distended, I think, as any patient I had ever seen with peritonitis, and the cause was evidently a case of gonorrhœal inflation. The husband had consulted me some two or three weeks previously to his wife's illness for gonorrhœa which had made its appearance that morning, and he said he was very much concerned for fear that he had communicated it to his wife. As the sequel proved his fears were well grounded.

DR. A. GREEN.—I think we can very easily explain how peritonitis may follow, at least in the female subject, an attack of gonorrhœa because we merely have to assume that the gonorrhœal virus has just extended with the same tissue, as the mucous membrane from the urethra to the vagina and into the uterus, and there it either comes in contact with the Fallopian tubes or it need not, and there it produces a perimetritis or a general peritonitis, or we may have what I think more likely, merely an attack of the lymphatics, not by pus but by a specific poison. If we actually have pus there, I think we would have septic peritonitis as a result. I do not think we actually have a peritonitis in all cases. But while we can explain how this result may be reached, I can't say that I am satisfid that we have a true rheumatism as a result of gonorrhœa. I have seen a good many cases of gonorrhœa, especially in the army, and I cannot now recollect of a single case in which there was gonorrhœal rheumatism following it. I must say that I am inclined to agree with Dr. Hughes, that this rheumatism would not be present in connection with the gonorrhœa, were it not for the rheumatic tendency—the predisposition of the person to rheumatism. I must say that I do not believe there is such a thing as gonorrhœal rheumatism.

DR. POLLAK—I wish to ask Dr. Chancellor if he ever saw a case of ophthalmia following gonorrhœa?

DR. CHANCELLOR.—I don't remember such a case.

DR. POLLAK.—You have never seen conjunctivitis and ophthalmia following gonorrhœa?

Dr. Chancellor.—I have never seen them simultaneously.

Dr. Pollak.—But not following?

Dr. Chancellor.—No, sir.

Dr. Moore.—I didn't hear the paper of Dr. Chancellor, having heard only Dr. Hughes' remarks. In regard to the treatment of these cases, was it anti-rheumatic?

Dr. Chancellor.—Yes, sir, generally with salicylic acid, salicylates, iodide of potash and jaborandi.

Dr. Moore.—And Dr. Atwood, I understand, has treated cases with ventrum viride?

Dr. Atwood.—Not veratrum viride internally but locally. I gave no veratrum viride. The viride was used merely as a counter-irritant.

Dr. Moore.—Was your internal treatment anti-rheumatic?

Dr. Atwood.—No, sir.

Dr. Moore.—Have you gotten better results by the anti-rheumatic treatment?

Dr. Atwood.—The anti-rheumatic treatment, as Dr. Chancellor states in his paper, gives no good results at all.

Dr. Moore.—He says his treatment was largely anti-rheumatic?

Dr. Atwood.—And he got no good results.

Dr. Moore.—Did no good results follow any treatment?

Dr. Chancelor.—I have found some good results from iodide of potash and mercury in two or three cases, but I cannot say I have found any positive results from any treatment; we have to wait until it wears itself out in the majority of cases.

Dr. Fairbrother.—I will refer to a case in point, and it seems to me that it goes a little way to illustrate a view contrary to that advanced by Dr. Hughes. The case in question occurred during the past summer. The patient was a most robust and healthy man—an Englishman who had gonorrhœa in July, and about the time of the subsidence of the gonorrhœa, a rheumatic irritation occurred in the left hip joint. This went on from bad to worse until he was unable to get out of bed. Through the month of September I treated him, keeping him upon the anti-

rheumatic treatment; still the case grew worse continually. Dr. Mudd saw the case, being called in consultation with me, and favored the anti-rheumatic treatment, accepting it as a typical case of gonorrhœal rheumatism, and not hoping for much from treatment; and our hopes were not disappointed, because he continued to get worse. He had to be lifted from the bed to the chair. The trouble was communicated or transferred from hip to the knee and ankle all on the left side. The anti-rheumatic treatment, according to the best authors of the present day, was pushed most energetically. He bore medicine well. He took it with enthusiasm, being anxious to get well; but nothing in the way of treatment had any effect whatever upon the disease. In November we decided to send him to Hot Springs. We fitted up a conveyance and got a car for him to go down there in. He had to be carried to the hotel, but improvement followed immediately after his commencing bathing at Hot Springs. It was really remarkable, and this is only one case of those that have come under my observaton, in which the rheumatism has improved under that treatment. This case grew rapidly better. In six weeks he came home, limping of course, but better in every way, and is in a fair way of getting well. He can walk without a stick. He is not entirely well, but considers himself so. This gentleman was of a most robust constitution, and was not depressed at all by the gonorrhœa; he kept at his work often sixteen hours a day, having charge of one of the elevators, and during the existence of the gonorrhœa, was not depressed; he said he never enjoyed more vigorous physical health than he did during the presence of the gonorrhœa.

DR. JOHNSTON.—Did you examine his urine?

DR. FAIRBROTHER.—No, sir.

DR. BERNAYS.—I am considerably interested in this question and I have been listening with pleasure, to the remarks, and it strikes me that the first question in regard to gonorrhœal rheumatism, is to find out whether there is such a thing or not; whether the causes of the inflammation of the joints, which the gentlemen speak of, are really the result of the gonorrhœa or not. One fact that seems to point in favor of the view that there is a connection between the diseases, is the fact that the patients have had repeated attacks of gonorrhœa, and each attack was accompanied by an inflammation of the knee joint. There

are several cases of that kind described. Now the next question is,—granting that there is such a thing—can we make the connection between the gonorrhœa and the rheumatism of the knee joint, or hip joint in a scientific way—can we make the pathology clear to ourselves. I can't see that the simple supposition of a sort of gonorrhœal diathesis brings us any nearer to an understanding, than we are without it. One case that I saw of gonorrhœa, which was followed by rheumatism in the knee joint, was accompanied by swelling of the lymphatic glands on the same side of the body where he had the inflammation of the joint. Now if it can be established that cases of gonorrhœal rheumatism are accompanied by a swelling of the lymphatic glands of the groin, then we are a little nearer to an understanding, and we can begin to understand the process of the disease. I related once before, in this society, that Langenbeck, the greatest surgeon of this age, had seen in his experience, some ten or twelve cases of hip disease, where he was compelled to perform resection of the joint in army officers in which he traced the disease of the joint to a gonorrhœa, the hip joint disease occurring upon a slight accident, a year or perhaps only six months after the gonorrhœa, and he accounted for it in this way, and I think his pathology of it is correct. He found in all these cases, a swelling of the lymphatic glands of the groin. Almost every case of gonorrhœa is accompanied by a slight enlargement at least. It need not be accompanied by the formation of a large bubo. He found that these lymphatic glands were in a state of cheesy degeneration, and from this cheesy degeneration perhaps, a small number of cells—which might be called a tubercle—there was a metastasis into the hip joint, causing cheesy degeneration of the hip joint, now of course, if there is a cheesy degeneration of any joint, the juices of the joint will be destroyed; the forces of nature seem to be very weak when there is a cheesy degeneration in a joint. Langenbeck claims that these cases where they could be traced to gonorrhœa were very severe.

Dr. Hughes.—Mr. President: the point which I wish to make is as to the appropriateness of the term rheumatism in connection with this trouble. It may be conceded that the term is appropriate if we understand, when we say gonorrhœal rheumatism, to mean simply gonorrhœal arthritis and nothing else. While I was at the Marine Hospital it was not uncommon to see

seamen—steamboatmen—in the hospital affected with rheumatism which had gonorrhœa as the exciting cause; but I consider that when rheumatism supervenes, it is because the rheumatic diathesis is there, and because the system has been depressed in consequence of the gonorahœa, and that is the exciting, determining cause. It doesn't do to appeal to anti-rheumatic treatmest in these cases. Our friend, Dr. Fairbrother, appealed to this treatment in vain; but the man got well at Hot Springs. Now, you may say Hot Springs is not anti-rheumatic treatment. It certainly is not anti-gonorrhœal. In this case I should have a suspicion that there was a lurking rheumatism in his system. In regard to Dr. Chancellor's cases; they recovered by the use of salicylic acid and iodide of potassium. Iodide of potassium is one of the best anti-rheumatic remedies we have. And in regard tonics, we know there is no form of disease that yields so readily to tonic treatment, as certain forms of adynamic rheumatism. It is said a large proportion of cases will recover by the use of a generous diet, a change of air and tonic treatment. I think we cannot exclude the hypothesis of a real rheumatic diathesis underlying these cases. The absence of acid in the urine does not indicate the absence of rheumatism or rheumatic irritation. It depends upon whether the amount of rheumatic irritation is great, or general, or not; and it is so far an undecided question whether lactic acid is a cause or a consequence of rheumatic disturbance. No pathologist has been able to determine that question. I am of opinion that it is coincident with, and not a cause of rheumatism. One of the bequests handed down to us by the blood pathologists is, that we must find everything in the blood.

Saturday, Feb. 24th., 1883.

Dr. Meisenbach.—Mr. President, I present for your consideration this evening, a case of stricture of the œsophagus. I took the specimen from a patient sixty-two years of age. The following is the history of the case: he complained last April for the first time, of feeling indisposed, and he attributed it to some disorder of the stomach. He passed into the hands of a physician some time during the summer and was treated by him until September, when he first began to have symptoms of rejection of food. He worried along in this condition until the 28th of December, when I saw him for the first time. At this time he was unable to swallow solid food, and retained only portions of liquid which was taken. When taken it would be regurgitated, similar to the way in which milk is sometimes regurgitated by a child when it is taken into the alimentary canal. When I saw him he had lost a great deal of fresh, and was emaciating. I made a careful examination of the abdominal wall and gastric regions. The physician who had seen him before had told him that his trouble was of a cancerous nature—that it was a cancer of the stomach. I found upon a careful examination and percussion no symptoms of infiltration, or of any tumor; the results were totally negative. There was no hardness in any portion of the epigastric region, and I came to the conclusion that the growth, whatever its character must be high up, at or near the cardiac orifice of the stomach. He lingered on until the 22d of January. Two days previous to his death he began to throw up quantities of fecal smelling matter mixed with blood, and he continued to do this up to the time of his death; this was due no doubt, to the rupture of some small vessels in or near the site of the growth. Now, as to the character of the growth, from the appearance of this specimen and from the previous history there is no doubt but it is cancerous in its nature. Strictures about the œsophagus are only of a few kinds among which are those that are congenital, those produced by traumatism, and those produced by neoplasm. Strictures produced by neoplastic growths are those that occur in middle age, never occurring in youth; and in cases where there is stricture before the time of middle age we have a conclusive history either of traumatism or the presence of a foreign body.

There are several sites where stricture of the œsophagus, either by preference, or for some other cause, are wont to occur

according to the analysis by Dr Harrison Allen of a number of cases of this disease. He states that there are two points at which he found it most likely to occur, and this specimen will substantiate his statement as to one of those points. The first of these is opposite the bifurcation of the left bronchus. Then again, we can positively state that this is an epithelial growth for various reasons, but first the character of the growth. Were it of a medullary character or of colloidal nature, the surrounding structures would be much more involved. This is limited in its extent. The questions of interest in these cases are the treatment and the nourishment. The treatment in cancerous stricture of th œsophagus is of course negative. There may be a justifiable reason, when the disease is not clearly defined, for passing the œsophageal bougie; but this is a very risky piece of business, especially if ulceration has already occurred in the growth, because there are numerous cases on record in which the œsophageal sound has been passed, not only into the mediastinum but into the pericardium, producing insanataneous death. Rectal alimentation is a very valuable means of prolonging life. This patient was kept alive during the whole time of my observation, a period of one month, exclusively I might say by rectal alimentation. The amount of liquid nourishment that he swallowed during this time must have been very little. The growth shows that there was not a complete stricture, but there was enough infiltration of tissue to prevent the passage of liquids. As I before stated, it shows that the growth occurs oposite the left bronchus. The specimen shows very nicely the infiltration, and shows also another point which by more careful examination will, I think, leave no doubt in the mind of the examiner of the epithelial character of the growth. Starting with the submucous tissue, I think by a careful examination of this growth you will this condition, which can be very clearly defined; you will find that there are portions of submucous tissue, that are free from infiltration, and as you progress upwards you find this infiltration becomes marked, that there is a gradual increase in the lines. The lungs of this patient were very much darkened, such as we find in habitual smokers. There was fatty degeneration of the walls of the heart. The walls were intact, the liver and kidneys showed signs of degeneration; there was a calcareous deposit in the capsule.

DR. MULHALL.—I would like to present another specimen.

The history of this case will probably not prove so interesting as the one Dr. Meisenbach has presented since this is not so complete, the case having passed from under my observation during the last month of his life. The history of the case is this: Richard W. aged 51, salesman, ten years ago contracted a hard chancre which was followed by secondaries, and he has had occasional slight manifestations since. Three years ago he had something similar to the present illness in New Orleans, which was cured in a few weeks with iodide of potassium. He came to me at the Throat department of the St. Louis Medical College Dispensary on December 29th., 1882. Five weeks before this time he began to suffer with his throat. His first symptom was cough and the ejection of frothy sputa tinged with yellow streaks—as much as a pint daily—the cough was very frequent, much worse at meals and often followed by vomiting. He had pain on swallowing only. Loss of sleep and appetite produced naturally a loss of flesh, so that he was quite emaciated when he came to the dispensary. The nose, pharynx and chest were normal. The lingual sinuses were very deep. The glosso-epiglottic ligaments were thickened, and showed evidence of former disease; the lingual sinuses were as I have said, very deep in this case, which is a point of practical interest. In the last number of the *Archives of Laryngology* there is a case presented in which the patient could swallow neither solid nor liquid food without producing persistent cough. Dr. Chapman, who reports the case, examined him and was at a loss to account for the symptoms until one day he asked him to chew and swallow a piece of beef in his presence. He did so and the doctor examining the larynx immediately afterwards found a piece of the beef lying in one of the lingual sinuses. He removed it with a brush, and the cough ceased immediately. He then investigated the case further and came to the conclusion that at the base of the tongue the parts were greatly atrophied, producing a very deep lingual sinuses. He told the gentleman that all that he could do for him was to instruct him how to clear out his lingual sinuses after taking food. The patient followed the instruction and has always thus relieved himself. This specimen shows a like condition; the result of thickening and contraction of the glosso-epiglottic ligaments. This will account for the unusual severity of the cough at meals. The right half of the larynx was, if anything, paler than normal, and studded over with pale, pinhead granulations. The tissues over the right ary-

tenoid were œdematous. The left half of the larynx congested and swollen, presenting ulceration of the left ventricular band and aryteno-epiglottic ligament. Trachea invisible. On December 29th I put the patient on a mixed anti-syphilitic treatment. I gave tonics and cod-liver oil and treated the larynx locally as well.

Local treatment consists in washing out the larynx thoroughly and then insufflating a powder composed of equal parts of iodoform, tannin and bismuth; this treatment kept him from coughing and gave perfect ease for twenty-four hours. I treated him for some two weeks and a half and as the laryngoscope showed him to be not much better, I had him sent to the City Hospital, where he remained up to Feb. 11th. (He had been in the hospital about a month.) When he died Dr. Dean very kindly preserved his larynx for me. On inquiry of the assistant physicians at the hospital as to the cause of the death, for I cannot see that the larynx was the cause of death, he only replied that the man would not take any food on account of the coughing and the pain that it produced, and that he would only drink milk. No laryngoscopic examination was made. He possibly died of inanition. The gentleman who made the post-mortem did not examine any organ except the larynx. Possibly the cause of death still remains undiscovered. The specimen that I have here shows an old radiating scar at the base of the tongue; the epiglottis is indurated; the ventricular bands on both sides are covered with granular growths, the left one being eroded. The left vocal cord at about the middle presents loss of substance; the right vocal cord is intact. At the junction of the cricoid cartilage with the trachea there is ulceration, and through the first and second tracheal rings perforations opening outside just under the left lobe of the thyroid gland. On the right side I dissected the tissues away overlying the arytenoid cartilage, and I have exposed the crico-arytenoid articulation without, however, discovering traces of disease. The left abductor is atrophied. The fracture of the thyroid cartilage is post-mortem; it is really more bone than cartilage—ossification being more advanced than usual at the age of fifty-one.

DR. LAIDLEY.—At the last meeting Dr. Hughes raised the question as to the advantage of amputation over the resection of the knee joint as exhibited in the case that I presented the night before. There is little difference in the result of these cases so

far as the lives of the patients are concerned; and now the question arises, which is the the most desirable, to have a limb retained as it is in this case, or cut it off. As one gentleman stated, you can not prove much by statistics. There is a great variety of opinions as regards the advantage of one or the other operation. I simply present this gentleman to exhibit the results in this case. The gentleman has a very useful limb. He walks with perfect ease.

Fig. 2.

Fig. 3.

Fig. 2. represents the patient before the operation. Fig. 3. represents the results of the operation.

Dr. Prince.—In regard to stricture of the œsophagus, I felt especially interested from the fact that I recently had a case of it; a child from Laclede, Missouri, of the age of two years swallowed a solution of concentrated lye. The result was that very soon there was a stricture of the œsophagus which entirely prevented swallowing of solid food. The child was nourished for two years and a half on liquid food—until it was four and a half

years old. This child would go several days unable to swallow even liquid food. The food swallowed would be retained for a considerable time in the œsophagus and then be rejected. I was encouraged in undertaking an enlargement of the canal in consequence of having ascertained the power of the negative pole of the battery in relieving stricture of the urethra. I think that it has been ascertained that the negative pole of the battery softens cicatrized material, hence the theory of success in my treatment of the stricture by this means making a metallic bougie the negative pole of the battery. An examination of the case showed that the œsophagus was clear of obstruction as low as a point opposite the bifurcation of the trachea. As has been explained in connection with the specimen exhibited to the society, this is one of the points of election of stricture. The treatment was commenced by anæsthetizing the child by the use of alcohol introduced into the rectum by the instrument presented to this society a few weeks ago, and so much ether as was necessary to keep up a fair degree of anæsthesia. There prove to be a disadvantage in the use of alcohol in this case. We used a current of 70 cells, measuring about eight pounds. I might mention that the child had an acute bronchial inflammation, in consequence of which a large amount of mucus was coughed up every day. The first treatment didn't seem to accomplish much, the instrument didn't pass through. The instrument employed was a flexible spiral bougie; flexible and bent to a spiral form with a steel point enclosed in a rubber tube so as to completely conceal it. As the ground seemed to be new I was fearful what the effect of the current on the spinal cord would be; but as the treatment went on without any catastrophe, the use of the instrument became more free. After the first sitting the child was able to swallow better. At the next sitting it was developed that the stricture was a prolonged one. The instrument passed the upper stricture in the lower third and into the stomach. There were six sittings in all, and at the last sittings the bougies were introduced; the bougie used at this sitting being no. 30 of the French scale; in fact several large bougies were introduced side by side. The child was now able to swallow bread and soft solids. At the seventh sitting a bougie of a larger size was employed, and after about ten minutes progress the child gasped two or three times and ceased breathing. Observations were taken and the temperature of the child gradually sank until the case was

given up in despair. Of course this disaster was a great misfortune on the eve of such a grand success in overcoming the contraction of cicatricial material resulting from what was practically a burn. The question arises whether that suspension of respiration was from inertia, or whether from the electric current. It was a pretty strong current, but it had previously made no manifestation of injury. Of course I am not myself decided as to what killed the child; it is quite probable that in some unfortunate manipulation of the instrument the point was carried too high up towards the medulla oblongata interfering with the proper supply of nerve force to the heart.

Dr. Porter.—The report that Dr. Prince makes to us is most interesting, and I was looking for some such result as this; not but what the methods of genius and almost any amount of risk are justifiable in such desperate cases, for even if the patients do not die immediately from the stricture, the life they lead is often worse than death; and yet it seems to me from the very nature —from the relation of the parts—there must be a great deal of danger in the use of almost any instrument in these cases for this reason. After the stricture has been present for awhile, dilatation of the œsophagus takes place above the stricture, and this dilatation is often so great that it will often contain a large amount of liquid, and we are taught by sad experience, some of us, and others by books and precepts, that there is oftentimes danger in the use of probes and œsophageal bougies in such cases; especially are we warned not to use much force because the distension being so great, and the stricture being almost entirely complete in many cases, the probabilities are that we do not enter the stricture at all. I believe often in these cases there is a spasmodic stricture above the point of dilatation, and that we often fancy we have reached the stomach; although careful measurement will often convince us we have not; and generally the instrument carrying the current would rest against the side of the sac rather than against the stricture. I do not mean to say that this would happen in the hands of one so skilled as Dr. Prince, especially if the child were under the influence of an anæsthetic, because a proper appreciation of the amount of force would secure him against great accident, yet it seems to me sir, that by using a powerful galvanic current such as must necessarily be used, that there may have been a perforation of the

wall of the sac. We can't tell. A post-mortem in this case would have been most interesting it seems to me. Certainly if there had been a perforation of the sac it would have reflected no discredit, because in this case the child was better off by being operated on with one chance in a thousand of relief, than to continue as it was. I do not believe in the use of electricity in such cases. It is a powerful agent and while it may do much good it may do much harm. The immediate cause of death was either from a perforation—which may have occurred—or from the powerful current near the heart. And yet we can scarcely say how that could be. Certainly I would not think that the death occurred from the anæsthetic because the electric influence would antagonize the depressing effect of the anæsthetic. I have had a good many strictures to treat, and I have never yet passed a bougie in one that I did not feel a sense of fear—a dread that I should push a little to hard on the bougie, and if it had been armed with electricity I should have been afraid of producing an absorption of the thin wall and producing a perforation of the wall. I do not criticize the treatment of Dr. Prince at all. I couldn't think of doing that, because the child was worse off than if dead.

DR. PRINCE.—I certainly think that this stricture was in the center of the œsophagus because the instrument would pass down and stop, and being manipulated so as to take another direction would pass through. There must have been a shelf formed on which the instrument impinged; and I will say further, that I found it more convenient to introduce the bougie through the nostrils than through the mouth. If passed through the mouth it required some handling and manipulating to get it through; whereas if passed into the nose it would pass directly through. I suppose the stricture must have been very far anteriorly, and if the instrument was carried far back it was enabled to pass the stricture more readily. Now with reference to the force necessary, I have learned by the treatment of the strictures of the urethra, by bougies carrying an electric current, the least possible force is the proper force to use, waiting until the stricture relaxes so that the instrument will pass easily. There is certainly an analogy between the two canals. Stricture of the urethra is an inflammatory result arising from a neoplasm outside the mucous coat; here we have a destruction of membrane and a

cicatricial product. In both cases the obstruction is cicatricial, and reasoning from analogy we may suppose that what will soften the cicatrix in one case will in another. With regard to the danger of the electric current I do not apprehend any danger if the current is introduced low down; but I fear that this catastrophe is an illustration of the danger of the current high up.

Dr. Dickinson.—How much ether was used?

Dr. Prince.—That cannot be estimated; very little. Alcohol was the chief anæsthetic employed.

Dr. Williams.—I would like to ask the doctor if he treats strictures of the urethra by electricity?

Dr. Prince.—Yes, sir.

Dr. Johnston.—I wish to say that I understand the doctor to say that electricity when applied to cicatricial tissue had the effect of softening it. Is that a fact? Does the application of electricity to cicatricial tissue produce a disorganization of it—does it cause a dissolving process? That is not my idea of the effect of electricity. I do not think it produces fatty degeneration, but my idea of its effect is that electricity paralyzes the nerves and therefore you have what is called a relaxation of the neoplasm—of the cicatricial tissue and not the softening process.

Dr. Holland.—I would like to ask the doctor what sort of nerve tissue is contained in the cicatrix?

Dr. Johnston.—I think if the doctor will read Rokitanski, Henle and other authors he will find there is plenty of nerve tissue in the cicatrix.

Dr. Hill.—I would like to ask Dr. Prince if he has ever applied electricity to an enlarged prostate and if so with what effect?

Dr. Prince.—I have resorted to it but with no good results; not sufficient to encourage the continuance of the treatment.

Dr. Love.—I want to say a word in regard to the case of resection and the propriety of the operation; and after having seen the limb again I still insist that if it were mine, taking into consideration the increased danger of the operation and the cumbersome stiff, obtruding leg which you cannot bring down

when you want to, that I would prefer, as I maintained before, to have my leg amputated.

DR. HURT.—In choosing between amputation and resection it seems to me allowable in surgery for the surgeon to pay deference to the choice of the patient himself.

SATURDAY, March 3, 1883.

DR. WILLIAMS.—I have a case which I wish to present, which will take only a few minutes. It is a case of orbital tumor. Now, this is a thing which is confessedly a difficult thing to diagnose. Some eight years ago this lady suddenly felt a pain in the orbit; from that time on, this swelling gradually made its appearance. At times it would fill up quite full, then again it would subside and nearly disappear for a short time, and then return again. Recently it has filled up as you see it, and has this inflammatory appearance. A few days ago it was not red and was not swollen as it is now. Last week there was hardly any swelling in it at all; so that it comes and goes. It is now in a worse condition than I ever saw it. I have satisfied myself that this is a cyst of the orbit, and of course, the diagnosis is an important point in this matter, because it determines the prognosis as well as the proper treatment. My diagnosis in this case is that it is a large cyst of the orbit. I call it a cyst for three principle reasons:

First. The tumor fluctuates, which of course, proves that the contents of the tumor is either fluid or semi-fluid.

Second. The tumor comes and goes, which could hardly be the case if the tumor was solid—if it was a solid tumor.

Third. This tumor has been opened by some physicians in the country, and the contents of the sac were discharged in the form of an albumoid substance, a thick, viscid albumoid substance.

These three reasons confirm the diagnosis, that this is a cyst. The prognosis, I think, is favorable. Of course, there is more risk in an operation on the part of the body so close to the cerebrum as this is; still I take it that the prognosis is favorable. I saw this case last summer, and at that time diagnosed it to be a cyst. I propose to open this cyst quite freely, to-morrow, and wash out the contents and keep it open freely until the sac closes up from the bottom, injecting in the meantime, some kind of

irritant such as we use in causing sacs or cysts to collapse or close up. Now if there is any mistake in the diagnosis, I would like to know it. The gentlemen can satisfy themselves in regard to the matter, by making the examination, and remember that these parts are tender; they are sore, so be kind enough to touch it lightly so as not to hurt it. I will say that the eyeball is perhaps out of position, forwards and downwards, but is in good condition and uninjured.

Dr. Pollak.—I am inclined to think this is an encysted tumor, in which the sac is ususlly very solid, very fibrous, supporting a lining membrane which secretes a fluid; after this has been punctured or irritated frequently, it becomes inflamed. I heard one gentleman say that glioma probably emenated from the sheath of the optic nerve. I must differ with him in toto; it is utterly impossible for such a tumor to rest against the optic nerve without causing absolute blindness. The smallest pressure on the optic nerve, sometimes not more than a single drop of serum, will cause blindness. Such a tumor as this, if connected with the optic nerve, would cause blindness. I think the tumor is not malignant: That it is benign. If the Doctor carries out the treatment that he has suggested, I feel sure that he will get good results, if he succeeds in removing the sac and evacuating the contents of the cyst.

Dr. Dickinson.—I understand that Dr. Bernays saw this case last summer, perhaps he will kindly give what he knows of the history.

Dr. Bernays.—The patient that we have before us came to my office a year ago, from little Rock, and asked me to make an examination of the tumor; and asked me the question, whether it could be removed or not. At that time the bulb was displaced much less than it is now, and it looked like a case of exopthalmus. Upon examination I discovered a round, slightly movable tumor, about equal in bulk to a hickory nut. She said she had been to several doctors, and that they had told her nothing could be done. My opinion was, and I told her that I might be able to reach the tumor if it did not extend too far back in the orbit. It does extend away back now, as will be found when it is removed. I have seen Baker perform the operation in Heidelberg, successfully; although the optic nerve may be stretched considerably, the eye protruding very much, the bulb will recede

and get into its place, after the tumor is removed. The tumor, I think, is a glioma, and I think a microscope will show that it is a glioma. The proper thing to do now would be to remove the eye, the whole of the bulb, and remove also parts of the bone from which it started. I think now, probably it started from the periosteum. At the first examination, I thought it started from the sheath of the optic nerve; either of those two places are favorite sites for the origin of mixomata or gliomata, and it is not possible to diagnose between them without the microscope. We know that gliomata occur chiefly in the orbit and in the nervous system also, upon the nerves themselves—on the sciatic nerve. Mixomata, on the contrary, occur principally about the hip, on the femur; however, they have also been known to occur about the orbit. If the woman asked my advice, now I would certainly recommend a very radical operation or none at all.

DR. DICKINSON.—I cannot agree with the opinion of the last speaker. I don't think it is a glioma; its history, its progress doesn't indicate to my mind that it is a glioma; what it is, I don't know; I should hesitate to give a positive opinion about it. I don't see any risk in operating as the Doctor proposes, and ascertaining its nature after the incision has been made. I say its history does indicate glioma. The glioma is aggressive throughout; The Doctor very properly says that the usual site of origin is within the globe, but it has been found in various parts, and even in the lens. The age of the patient seems to me to miliate against a glioma. It is rarely that we find it in the adult; the oldest case that I remember of having seen, was in a patient thirteen years of age. I think there are some on record, in which the patient was older, still she has suffered a long time, and it is time that something decisive should be done. When I first saw this case at a distance, it reminded me of a case I saw last summer, which presented an appearance very similar, but in that case the exopthalmus was produced by an osseous growth.

DR. BERNAYS.—Not being a specialist in this line, I would suggest that Dr. Green, who examined the case at the same time I did, could probably help to clear up the matter. I am almost certain that it is a malignant tumor, and that he thought so at the time he examined it.

DR. POLLAK.—I would like to ask Dr. Bernays if he ever saw

glioma in the eye that there was no blindness? I never heard of such a thing—I never saw such an instance in my life.

Dr. Bernays.—I rise to make an explanation. There are cases of the kind. I saw a case of glioma, removed one myself which was attached to the ontside of the sheath by adventitious tissue, connective tissue of the sheath of the optic nerve, and had nothing to do with the nerve part of the optic nerve.

Dr. Mulhall.—I have been announced to read a paper on the subject of hæmorrhage in connection with malaria. That is a misapprehension. I stated at the last meeting, that I would offer as the subject for discussion, that subject based upon clinical cases. I would like to have read a paper on the subject, but its very obscurity convinced me that it would require very extensive biblio-graphical research, the facilities for which did not exist in St. Louis. I will give a statement of some cases of hæmoptysis and epistaxis, for relief from which the patients applied to me. The first case was a lady who was sent to me, who applied for relief from hæmoptysis. Before coming to me she had been spitting blood for about four or five months, not at regular intervals; the intervals averaged perhaps ten days. There was never any profuse hæmorrhage; it was always in small quantities, and sometimes mixed with frothy sputa, generally erated. She said that her nose had bled, at intervals, for four or five months. During this time her nose bled for two days at one time, five days at another, and three days at the third; the hæmorrhage from the nose was bilateral, was never rapid in its action, but was on the contrary, an oozing, so she did not lose very much blood. It would bleed a drop at a time, and very slowly. I inquired into her family history and found no family or personal history of gland or lung trouble. She stated that she went to Arkansas in the fall of 1879, I think, somewhere in the neighborhood of Little Rock, and soon acquired the ague. That was in 1879. She says the paroxysms were broken up with whisky and quinine; but after awhile she relapsed into chronic malaria, the quinine gradually lost its effect, and when she came to me in the spring of 1882, she had a regular Arkansas complication. Her system was saturated with malaria; skin was yellow and she was somewhat emaciated and there were a number of bleeding points at different parts of the body. I examined her very carefully with negative results. Taking her family history into

consideration and the fact that before the attack of malaria, she had never suffered with hæmorrhages, I gave as my opinion that very likely if the malarial disorder was cured, the hæmorrhages would cease. I gave her iodide before meals, ten drops; four drops of Fowler's solution three times a day, and allowed her to drink Hunyadi Janos water and kept the bowels gently open. During these three months she bled three times, and I then put her on the anti-malarial treatment, such as iron, quinine, arsenic. She improved under this treatment and left the city. I have heard from her since, and she stated that she had recovered her health perfectly.

The second case was that of a man named George H., who lived in Carondelet. He was a fireman on the railroad, and applied at the throat department of the St. Louis Medical College dispensary, May 25, 1882, for relief for bleeding at the nose. He told me his nose had been bleeding for a week. His family, as well as his personal history, gave no indication of gland or lung trouble. I examined his nose and found that the anterior nares half way down the pharynx was covered with a black crust of blood and I thought it was a rather strange thing. He was then a healthy man with a good family history, and I thought it strange that he should be suffering from hæmorrhage—this blood oozing. In order to invesigate further, I made the man strip to the waist and upon looking at the skin, I found quite a number of ecchymosis, and the question was asked if a slight injury would not produce ecchymosis; I said yes, and I remember that several of the students gave him several light taps on the arm in order to see if it would produce bleeding in the subcutaneous tissue, and we afterwards saw that there were several small marks of subcutaneous bleeding. He said that eighteen months before, he had been the victim of intermittent fever, which had lapsed into chronic malaria afterwards, but that he had never had any bleeding from any part of the body until six months before. When he applied to me he had bleeding of the nose, he told me he had lost blood by the bowels; and that the scratch of a pin, or a slight injury produced serious bleeding. He was rather pale and anæmic. I thought that probably he might have Bright's disease, and I examined his urine but found nothing there. I then put him upon anti-malarial treatment—large doses of quinine. He came back in a week and said he felt better. He then disappeared and I did not see him for two weeks, when

he came to the dispensary because his nose was bleeding again, and he also had bleeding of the gums, without any laceration or appearance of solution of continuity; there were also on the hard and soft palates, numerous apunctiform hæmorrhagic spots. I asked him if he had been suffering with fever and chills, and he told me that he had been suffering with it again. He said that since I had seen him last, he got very much better, in fact, he considered himself well; he had no hæmorrhages whatever; his color returned and he was able to go about. I instituted the same treatment again. This man evidently had a regular hæmorrhagic diathesis; he was liable to bleed from any portion of the body. Now, the question that presented itself to me was whether the malaria might not produce this effect. In the first case the effect was milder, but in the second case the trouble was general. I have no theory by which to explain the trouble, but with the permission of the society, will read something from a pamphlet read by Dr. Stephen Mckenzie, before the Hunterian Society, in 1877, on the subject of "Retinal Hæmorrhages and Melanæmia as Symptoms of Ague." He says:

"Retinal hæmorrhages, (or retinitis, as the condition would be described by many ophthalmic writers) so far as I am aware, have not been noticed specially in connection with ague. In fact, the observations recorded of the condition of the retina in malarial disorders, are few in number. Dr. Hammond, in a paper published in the Transactions of the American Neurological Society, in 1875, on 'Pigmentary Deposits in the Brain, Resulting from Malarial Poisoning,' has described ophthalmoscopical alterations from melanæmia, the result of malarial poisoning.' In one case Dr. Hammond says, 'Upon examining the fundus of the eye with the ophthalmoscope, I found double optic neuritis, worse on the left side than on the right, and large deposits of pigment in both retinæ, especially the left. These masses were stellate in form and followed, mainly the course of the arterial branches. I then punctured tha spleen and drew off a few drops of blood. Examined by the microscope, it was found to contain a large quantity of free pigment holding cells. Prof. Roosa examined this patient and confirmed Dr. Hammond's observations as to the ophthalmoscopic appearances.' Of another case of malaria with choreic symptoms, Dr. Hammond says: 'On examining the eyes with the ophthalmoscope, I found numereus deposits of pigment, stellate form, along the course of

the arterial branches on both sides." And of another case he says, "There was no abnormal ophthalmoscopic appearance beyond choked disc on both sides." Dr. Hammond does not appear to have observed retinal extravasations in his cases.

["Since reading the paper I find that M. X. Galezowiski, under the head of 'Affections de la Retina du Berf Optique dans la Fievre Palustre' at page 190 of his 'Traite Iconographique d'Ophthalimoscopie' (Paris, Balliere et Fils, 1876) has described the occurrence of retinal extravasations in connection with ague. He writes: 'The accidents which occur in the different forms are proportionate to the gravity of the malarial diathesis. In the common form we have distinguished a kind of apoplectic and exudative retinitis with peripapillary serous infiltration, which yields readily to anti-periodic treatment. To give an example which we observed with our disiinguished friend and colleague Dr. Noel Gueneau de Mussy. A schoolboy was siezed with violent headache and intense fever, some days later he complained of defective sight, and on examining him with the ophthalmoscope we found double neuro-retinitis with multiple hæmorrhages. After an emetic the desease presented all the characters of a tertian ague, and later fifty-centigrame doses of sulphate of quinine administered for some days produced a cure both of the fever and of the neuro-retinitis.' M. Galezowisik also mentions atrophy of the papilla and marked diminution of the central vessels in cases of chronic malarial poisoning."]

"But whilst hæmorrhages into the retina do not appear to have attracted attention in connection with malaria, hæmorrhages into the brain and its membranes have been described by most writers on the anatomy of the disease. Freirichs states that obstruction of the capillaries by pigment and fibrinous-like coagula leads to the formation of many capillary apoplexies. He states that Planer described eight cases in which small extravasations were scattered through the grey and white substance of the brain. He adds: 'These numerous hæmorrhages have not come under my own observation, but in two cases I have observed extravasations into the meninges.' Further on he writes: 'I have seen paralysis make its appearance suddenly, and here capillary hæmorrhage was found.' Niemeyer says: 'In autopsies of persons who have died of pernicious intermittents we often found signs of melanæmia, and occasionally remains of inflammative effusions of blood, or excessive hyperæ-

mia in different organs.' Hertz in his exhaustive monograph on 'Malarial Diseases' mentions 'numerous punctiform extravasations which have been thought to depend on blocking up of the capillaries by means of pigment matter, and represent capillary aneurisms.' Wagner also mentions that capillary hæmorrhages have been found in the brain in connection with malarial melanæmia, and also in cases of malarial poisoning without melanæmia."

"It would therefore appear that hæmorrhages into nervous structure are not unfrequently met with in fatal cases of malarial disease. The hæmorrhages are not confined to these parts, however. Hertz states that ecchymoses are found in the endocardium and pericardium, and small hæmorrhages have been found in the heart muscle. The liver is sometimes found studded with apoplectic spots, and the mucous membrane of the stomach and intestines has been found ecchymotic."

"But besides these post-mortem appearances, hæmorrhages are not at all uncommon during life, and in non-fatal cases. Intermittent hermaturia is a well-known malarial affection. Hertz writes: 'Hæmorrhages from the nose are frequent.' (This is interesting, as epitaxis is common in the form of Bright's disease which is commonly attended with retinal apoplexies.) 'Those from the female genitals or from the stomach and bowels, rare; petechia appear upon the skin, and a scorbitic condition is sometimes developed about the gums.' Dr. Sinclair has recorded a very interesting case in which intermittent epistaxis appeared to be due to malarial influence and yielded to antimalarial treatment. Surgeon-Major Porter read a paper last year at the royal Medical and Chirurgical Society on 'Recurrent Hæmorrhage' from the amputated stump of a patient who had formerly suffered from malarial affection. Each attack of hæmorrhage was ushered in by a cold and hot stage resembling ague."

"It will be seen that the majority of, though not all, writers who have described hæmorrhages into the brain and other organs have been inclined to attribute them to the melanæmia which has been so frequently observed in association with them. It has been held that the pigment cells, by blocking capillaries, lead to fluxionary extravasations or rupture. The retinal hæmorrhages observed in the case of ague I have narrated might, therefore, be naturally referred to the melanæmia which cöexisted. I very much doubt, however, whether we should be

justified in concluding that there was any direct or necessary connection between the two. This point—the stage or severity of the disease—appears to me to be of importance in determining hæmorrhages for it will be seen that the three cases in which hæmorrhages were noticed, in the two in which the hæmorrhages were well marked the ague was of the quotidian type; in the other case, in which there was only one small hæmorrhage, the ague was tertian. In the ship-mate of the two patients at Greenwich, who had no hæmorrhage the ague was irregular. Moreover the other cases examined by Mr. Atkinson, and found to be free from hæmorrhages, were patients about to be discharged cured from the hospital. In the few chronic malarial cases I have examined I could find no extravasations. If, therefore, retinal hæmorrhages are at all frequent concomitants of ague it would seem that they may be expected to be found in the early stages of the affection, when the disease is most active, and the paroxysms occur at short intervals."

"It should be stated that none of the patients in whose eyes I have found hæmorrhages complained of loss of sight or any ocular trouble. This shows the importance of the routine use of the ophthalmoscope in medicine, as so strongly insisted on by my colleague Dr. Hullings-Jackson. In Galezowiski's case it will be observed there was defective sight"

"As to the cause of the retinal hæmorrhages, I should conjecturally refer it to an altered condition of the blood. Retinal hemorrhages are found in pernicious anæmia, leukæmia, purpura, diabetes, and several other diseases characterized by alterations in the blood."

"It is an interesting fact that retinal hæmorrhages have been described by Roth in pyæmia, a disease which shares with ague, more almost than any other, profound alterations in the blood and repeated rigors."

"Retinal hæmorrhages in connection with ague may be much less frequent than would appear from the cases that I have brought under the notice of the society. I hope I shall not be thought to overestimate their importance, or to generalize from one or two chance cases. I merely wish to call attention to the fact that they have been observed in three cases, and would ask those who have an opportunity to examine with the ophthalmoscope the eyes of patients suffering from ague. Should hæmorrhage be found of frequent occurrence, they may in doubtful

cases have diagnostic value, as have the intraocular changes in Bright's desease and diabetes."

Dr. A. Green.—Malaria may give rise to hæmorrhage, especially hæmorrhages from mucous membranes. I have had under treatment a good many such cases; some had bleeding from the nose, some from the female genital organs and so on, which I recognized as being of malarial origin. I treated them accordingly and they got well. I think almost every physician who has been practicing for some time has had more or less experience of this kind; it is nothing new. There is one thing that I do subscribe to: that is that the hæmorrhage diathesis is an hereditary disease. We have whole families of bleeders, Mr. President. There is a bleeding which we meet with in certain persons which we can trace back to the family history. The most interesting point about it I think is that the male offspring are more exposed to it than the female; so much so that it will attack males in the proportion of about twelve males to one female. Then again the spreading of diathesis is done mostly if not altogether by the women; that is by the mother and not by the father. It is very seldom that if a man with a hæmorrhagic diathesis marries a healthy woman that his children will have the disease. He does sometimes, but there is no rule without exception; but if the mother comes of a family in which there exists the hæmorragic diathesis, although she herself escapes the disease it is almost sure to affect her offspring, especially the female offspring. And then again sometimes the disease will miss one generation altogether and attack the next generation. But you may take it for granted that the hæmorrhagic diathesis is an hereditary disease. Now these bleeders may go for a number of years without any indication of the trouble, but as soon as any poison affects the system it may give rise to this bleeding. In the case Dr. Mulhall speaks of we cannot say that the man had a hæmorrhagic diathesis from the malarial fever simply because he had ecchymosis under the skin.

Dr. Mulhall.—I was announced to read a paper on the hæmorrhagic diathesis; now if I had been called upon to give a distinctive title to my remarks I would have given: "Hæmorrhages in Connection with Malarial Fever." There is a tendency among the members to wander off on something else besides the subject of the paper or subject under discussion. I

didn't purpose to speak of the hæmorrhagic diathesis, but simply hæmorrhage in connection with malaria.

DR. BERNAYS.—I only want to say a few words in regard to this subject. I have been very much interested with Dr. Mulhall's remarks and sentiments. I think his idea is eminently correct. I think that we in this country who have had cases of chronic malaria on hand all the time ought to be the persons to decide whether chronic malaria produces the hœmorrhagic diathesis or not. Hæmorrhagic diathesis means a tendency to the rupture of small blood vessels and capillaries, causing hæmorrhage, and these cases often continue a long time, because the blood is so thin and has lost so much of its fibrine, that coagulation of the blood will not take place readily. We know that coagulation of the blood depends on a certain kind of fibrine that is in the blood which causes the coagulation. That is the subject of a paper that received the prize, it was by Alexander Schimdt. He was the first one to undertake to account for the coagulation of the blood in a scientific manner. I think the doctor's position is correct; I think I have seen cases of chronic malaria where the blood was in such a condition that it would ooze through the coats of the blood-vessels and, of course, there was a great tendency to hæmorrhage. I don't think the speaker tried to convey the idea that hemorrhagic maculosus was caused by malaria. I think Dr. Green misunderstood him.

DR. ATWOOD.—I didn't suppose that any such controversy as this would arise. I supposed that we in the Mississippi Valley all recognized the fact that hæmorrhages are sometimes dependent upon chronic malarial fever. It is not confined to malarial fever, however. It is seen in several types in the plague, in cholera, it is seen in death by lightning, it is seen by the impression of a powerful mental shock, it is seen in the ligation of the femoral artery in inferior animals. It is not dependent on the non-coagulability of the fibrine of the blood or by the rupture of the minute blood-vessels and capillaries as Dr. Bernays says, but it exudes through the walls of the blood-vessels owing to the relaxed condition of the part. There was a theory at one time that purpura hæmorrhagica was dependent upon a defective state of the middle coat of the blood-vessels, but nobody believes that any longer. But it is caused by the defective, relaxed condition of the coat of the blood-vessels which

permit the blood to escape through them. Now, with regard to hæmorrhage being independent of the malaria, anyone who has had much experience in the treatment of malaria must, as a matter of course, have seen a great many patients who have had hæmorrhages—slight hæmorrhages from the bowels. In all these cases, so far as my experience goes, in almost every instance the patient has stated that he feels much better, and wishes to put on his clothes and go out, and in a few hours, or almost immediately, has a hæmorrhage — sometimes a very profuse one — as much as a chamberful of blood would pass and the patient would almost be brougnt to death's door. In regard to the case which Dr. Mulhall reports in which there was hæmorrhage from the nose, I will say that this is the most ordinary site from which the hæmorrhage occurs. We almost always have it in connection with the ague. I don't think there is any doubt about the correctness of Dr. Mulhall's view.

Dr. Fairbrother.—It is always interesting to connect one fact with another—symptoms with their causes. It would be interesting in connection with the paper which has been read to-night—it would be an interesting matter if in cases of purpura hæmorrhagic diathesis we could refer them to a relaxed condition of the vascular system, the result of a profound impression produced on the vaso-motor system, but as it takes more than one swallow to make spring, so it takes more than two cases to established a theory or a presumption. While hearing the reading of the paper I ran over as far as my memory enabled me all the cases relative to the hæmorrhagic diathesis that have come under my observation within the last eleven years, and so far I cannot remember one of them in connection with a malarial case; and yet, as most of you are aware, my experience with malaria has been more or less extensive; and further it has occurred to me on the contrary, that there is a tendency in malarial conditions of the system—that is in the condition which we generally understand as malarious, although that is the scapegoat for a vast amount of ignorance, and it would be a pity if we here to-night saddle upon it anything more—but I was about to say that in conditions of malarial poisoning I have been inclined to think that the tendency to hæmorrhage was lessening. I can certainly remember some cases of abortion in patients who were suffering with malarial fever, and there was scarcely any bleeding; I

remember, also, a case of uterine hæmorrhage—a tendency to uterine hœmorrhage that stopped during the existence of the malarial affection; it has occurred to all of you no doubt in cases of malarial fever in females that there has been a cessation of the menses during the attack of malaria, and for months afterwards until the blood was re-established.

DR. SCOTT.—In connection with this discussion of malarial poison and hæmorrhage I would like to report a case or two that occurred in my practice. In September I was called to see a gentleman in fine health, and whose family is healthy—all healthy people,—when I say he was in fine health I mean that there is no hereditary tendency to disease of any kind in his family, of course he was not well when I was called to see him. I found he had what is called typho-malarial fever. It was rather of a slow form,—more typhoid than anything else—I would almost call it typhoid fever. He went along until the 26th, day nothing unusual occurring; on the 26th, day he was able to be up, and got out of bed and walked into the adjoining room upon the arm of an assistant. His temperature had been very high; his pulse was 100; his temperature was at times 107°, but had gone down and was almost normal. On the morning of that day I saw him and he seemed to be comfortable. I called to see him again in the evening, as I was in the habit of making two visits a day, and found his temperature was 105 and 7-10° and his pulse over 100; here was a sudden increase of temperature and a rise in the pulse for which I could not account. I could not understand why this was the case; I realized that I had some enemy to deal with, that there was lurking mischief some where. Realizing the fact that one of the most serious complications which we are apt to have in malarial fever is some implication of the lungs—bronchitis, pneumonitis etc, I gave the patient a thorough examination. I found no trouble in the lungs and I then turned my attention to the abdomen and examined it very carefully, recognizing the fact that in these cases we frequently have ulceration. I examined him very carefully to see if there might not be some point of tenderness somewhere about the abdomen; I found none. Over the right iliac fossa there was a slight indication of pain on pressure, but not more than we find in ordinary cases. I was now completely nonplussed. I did not know what to do. I felt certain that there was something wrong somewhere that would

develop itself. I gave the patient something to quiet him during the night and left him. The next morning I was called to his bed-side in a very great hurry and found that during the night he had had an enormous hæmorrhage from the bowels; as many as four large chamberfuls had been carried away from him. I immediately put the patient on ergot and iron. I called in the afternoon and found that he had no more discharges of blood from the bowels, but that he had had a slight epistaxis. I plugged his nostrils and again visited him late in the evening. There had been no more hæmorrhage from the nose. I still kept the patient on ergot and iron. Knowing that these hæmorrhages are more apt to occur at night than at any other time, I directed that in case the hæmorrhage came on, my friend, Dr. Prewitt should be called in, the doctor living in his neighborhood. I then called on Dr. Prewitt, and asked him if he would call and plug the man's nose in case hæmorrhages came on. During the night the hæmorrhage came on, and Dr. Prewitt was called and plugged his nose. When I called the next morning the doctor had visited the patient, and I found that the blood was oozing from the patients nostrils; and we found that there were large blood blisters under the clavicle, over the chest and abdomen—he was covered with epistasillary spots, and not only was that the case but he had hæmorrhage into the conjunctiva, so that it will be seen that his whole blood was completely, thoroughly poisoned. I abandoned the ergot and iron now; the hæmorrhage of the bowels had ceased; and tried a remedy which I had used in the treatment of malaria in my country practice long ago—I had long since learned that it was one of the best hæmostatics that I had used; it is spirits of turpentine. I put the patient on turpentine. He had one or two hæmorrhages from the nostrils after this. I kept the patient on spirits of turpentine, increasing the dose. I gave at first 15 or 20 drops and I increased it to 30 drops every three hours; and I will say that the best way of giving turpentine is in a capsule—not having it put up at the drug-store—but putting it in the capsule just before giving it to the patient. Well, I put the patient upon this treatment, giving him a supporting diet; and I am pleased to say, that although my patient was reduced to Death's door, and several of my brother physicians said that he was bound to die—that there was no hope at all and indeed there was no reasonable hope for him—yet he did make a recovery and is doing well. At the same time I was

attending this young gentleman I had two other cases on hand. One a young man who had malarial fever, had an enormous hæmorrhage from his bowels, but there was none of the hæmorrhage under the skin in his case; at the same time I was treating another gentleman on Madison street, 60 years of age, who had malarial fever; he also had some hæmorrhages from the bowels. I put all these cases on the spirits of turpentine, and they all got well. I think the hœmorrhages were dependent upon the malarial fever.

ARTICLE XLI.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

[Reported for the JOURNAL.]

THURSDAY EVENING, Jan. 25th, 1883.

The President, DR. JAS. TYSON, in the chair.

The Morphiology of Pulmonary Phthisis, by Dr. Edward T. Bruen.

I have been requested by the committee on arrangement to present some considerations bearing upon the pathological anatomy of phthisis, as a basis for the discussion of the subject before the society. The etiology of phthisis is very properly exciting careful attention at present, but the subject is in a far too unsettled condition to permit even a useful discussion. I shall not therefore allude to it, and I feel that I must offer an apology for the triteness of the subject matter of my paper, but I was informed that it was designed to have a series of discussions upon familiar pathological conditions. With this understanding my scruples have been overcome. A consideration of special interest seems to me to be connected with the morphiology of primary tubercle. In certain individuals owing to inherited tendency, or particularly unfavorable surroundings, recovery after bronchitis due to cold, is retarded, or a susceptibility to a new bronchitis is increased. In either case lingering catarrh in the majority of instances is the inception of the series of pathological processes known as phthisis pulmonalis. Two

microscopical appearances nearly identical occur, but they differ materially in their microscopic anatomy. Certain so-called miliary tubercles are frequently composed of the inflammatory products of connective tissue, without the characteristics true to tubercular arrangement. The word miliary, expresses their appearances, but the inflammatory products may be so arranged as to represent true tubercle, pseudo-tubercle or a diffuse inflammation. This tubercle or pseudo-tubercle is constant in the different forms of phthisis in the adult, except in the instance of pure interstitial pneumonia. Frequently the amount of tubercle tissue in the lungs is so great as to form the principle part of the process, although complicating inflammatory cheesy products are also present.

Classification of phthisis.—The term tubercular peri-bronchitis is probably the best for the earliest stage of phthisis, and sometimes is the best to designate the process all the way through. The appearance of the peri-bronchial tissues resembles berries on a stalk. The formation extends along the bronchi, spreading from a cinus to a cinus until the trunk is reached, and is also distributed in the sheaths of vessels and lymphatics. True tubercle may penetrate a bronchus and involve the lining membrane, and a true tuberculous ulcer may form the basis of an extensive associated bronchitis. Aside from this, these infiltrations excite inter-lobular connective tissue growth, and subsequently the walls of the vescicles become thickened, and some vescicular catarrh ensues which may occlude a lobule. Thus the three divisions of the pulmonary tissue show in the pathological process of early phthisis. The cause of more than nineteen twentieths of vesicular consolidation is the result of a process of desquamative pneumonia. This term is used to describe the diffuse inflamation, which may accompany the former process, and which more than the other changes paves the way for the disintegration of the lung. In this process the peripheal epithelial cells of the bronchi are proliferated and shed, thus filling the bronchi and infundibula, while the surrounding connective tissue becomes infiltrated with cells. In children this process is a common one on account of the greater cellular activity in these subjects. In the desquamative catarrhal pneumonia of early life the process differs from the desquamative pneumonias of adults in that the air cells only are filled, and there is little or no change in the intervescicular tissue. Hence

it is that rocovery is so much the more frequent in children then in adults. This process of desquamative catarrh is the base of those cases of acutely developed phthisis which follow croupous or catarrhal pneumonia, and which has been called acute catarrhal phthisis or galloping consumption—sometimes pneumonia phthisis. When the pathological process just described is less rapid the result which follows has been classed by some as acute casious pneumonia. When the changes are still more slowly develoved it is synonomous with the chronic catarrhal pneumonia. The relative developement then of these processes known as phthisis in the three divisions of the pulmonary tissues, the bronchial, the inter-lobular and the vescicular is denominated by the activity of the inflamatory process. Peri-bronchitis with consecutive changes in the latent forms, desquamative pneumonia in the more acute forms. While a process presently to be alluded to—interstitial phthisis—occurs as a very slowly developed change. In many of these cases when the destructiou of the lung is very rapid the tubercular deposition, true or pseudo, occurs in early stages, but is masked in the later by the developement of the secondary inflamatory desquamative pneumonic processes. The situation at which phthisis is developed is probably most frequently the apex. The forces of expiration presumably are least efficient at this site, and the lungs are less entirely freed from mucous. The circulation also is less than at the roots, and the products of inflamation are therefore more dry. The roots of the lungs, however, in a large majority of cases, are primarily affected. This is especially true of cases in which the original processes of invasion are latent. I pause here to observe a clinical point of some interest, viz: that when the area of lung involved in the process of phthisis, is distinctly limited and does not shade off gradually into healthy lung, my opinion is that a favorable result may be very possible. Certainly I have seen the process of phthisis arrested even when it had passed into the stage of cavity when the lesions were sharply defined. The localization of a lesion, other things being equal, is a point of favorable prognosis. Another topic of interest is the share taken by pleurisy in the developement of phthisis. A specimen already exhibited before the society, is again shown to-night. It is taken from a colored man, seventy years old with a family history free trom the taint of pulmonary disease. He was tapped

five times for the relief of hydrothorax due to heart failure. Each paracentisis was followed by an exacerbation of pleurisy. Nine months after the first operation death occurred from an increase of hydrothorax. The autopsy disclosed general miliary tuberculosis of the pleura and secondary deposits in the viscera. Throughout the parenchyma of the lung, adjacent to the pleura, there was copious deposit of tubercles, but the other parts of the lungs were normal. Another specimen exhibits the same tendency, viz: general pleurisy with phthisis and cheesy deposit in the pulmonary parenchyma, with cavities. The deposits are most abundant near the pleural surface of the lung, the deeper parts evidencing a more recent date of formation. These specimens show that pleurisy may give origin to the tuberculosus inflammation. But while this is true it is conceeded by all that dry pleurisy is a frequent secondary lesion in the process of pulmonary tuberculosis. Pleurisy is, however, in many cases very conservative, since by the thickening and adhesion of the pleural surfaces, the ulceration of the walls of superficial cavities is arrested pneumothorax is prevented. Interstitial phthisis or cirrhosis is a process in which true or pseudo tubercle may or may not be associated. The pulmonary tissues are traversed by narrow bands of connective tissue which may gradually compress it more and more, finally converting it into dense fibrous masses. The color of the lung is apt to be slaty and dark. However, in some cases of Interstitial Phthisis patches of the peri-bronchial and desquamative pneumonia may be found with cheesy degeneration. Intersticial formation is an important part of the process by which cavities are enclosed and sometimes cicatrized.

Distribution; Interstitial phthisis, if consecutive to bronchitis, is usually bylateral affecting the upper lobes, although as a unilateral affection it is not infrequent Syphilitic Phthisis. It is of interest to note in this connection that the early lesions of the syphilitic phthisis, so-called, are evoked very often by bronchial catarrhal inflamation, which predisposes to structural changes. In these cases there is a principal intersticial fibro-neucleus growth commencing in the alveola wall and concentrically arranged around the smallest bronchi and pulmonary vessels. Wagner maintains that the alveola wall is implicated, as commonly in syphilis as in ordinary phthisis. Bronchial narrowing occurs in these cases, by the pressure of the new

growth which developes along their lumen. Bronchial occlusion may occur from this new formation but it is also caused by the enlarged bronchial glands, one of the effects of syphilis. By this means serious mischief in the lungs may be developed, in kind proportion to the degree of distinction, such as atelectasis, emphysema, and certain forms of pneumonia. Green and Vichou suggest that the origin of syphilitic diseases of the lung is distinctive in this respect, that while in ordinary phthisis the fibroid is secondary or co-equal in its developement with changes in the alveoli and alveola wall; in syphilis there are primarily principle interstitial changes. Later when entire vesicular consolidation and breaking-down occurs, the process is similar to ordinary phthisis and indestinguishable from it. The vascularity of the new growth of connective tissue is also claimed to be a distinctive characteristic of the inflammatory proliferation due to syphilis. But we must remember in any discussion of early syphilitic lung disease; that the one special and characteristic lesion of syphilis is the change in the blood vessels. This has not yet been demonstrated in the lung, but merely the general thickening of the external coat of the vessels. In the effect of the instertitial processes upon the bronchial tubes the syphilitic differs from the non-specific disease. The tough contracting fibrous tissue which radiates through the lung draws together the bronchial tubes and deforms by narrowing or flattening them, possibly even to obliteration. On the contrary in the forms of non-syphalitih fibroid phthisis the bronchial tissues are widened. The process proceeds in syphilis from the hilus into the interior of the lung, following the tract of the bronchial radicals and the bronchial arteries. The lesions also occur on the surface, near the visceral pleura, where there is also more connective tissue. Gummata occurs as a later process. Time will not allow me to allude to these as I should like. A demonstration of the pathology of phthisis, would be incomplete without concluding some cases of true miliary tuberculosis. This process may be primary in the lungs or secondary as a part of the general infiltration of the serous and mucous membranes, the lymphatic glands and the viscera. This form of tubercle is characteristically recognizable only in the miliary stage. Its appearance as a number of small, hard, translucent nodules is too familiar to need description. A specimen on the table illustrates an extensive lymphangitis of the pulmonary pleura,

forming a network over the pleura. The process microscopically, shows a dense tissue in nodular form. Similar cases have been described before the London Pathological Society in 1880.

Enlargement of the Bronchial Glands.—Another important part of the phthisical process is the enlargement of the bronchial glands. They present a firm, pigmented character and the connective tissue is usually infiltrated. I have observed in many cases in individuals suffering from temporary catarrhal conditions of the bronchial mucous membrane, especially when there is a family history of inherited phthisis, but particularly distinctive scrofulous persons, a set of symptoms referable to enlargement of these glands. These symptoms consist chiefly in the alteration of the rhythm of the breathing, presumably from pneumogastric irritation is apparent inability to fill the chest with air and a sense of suffocation is complained of. Added to these there is pain in the back to the right or the left of the second dorsal vertebra. Further detail of the clinical ensemble would carry one away from the pathology of the subject. When the enlargement of the bronchial glands is excessive it may occasion severe mediastinal pressure and pain becomes an important clinical symptom, and is of the sort occasioned by mediastinal growth generally. To detect this enlargement during life Guineau de Mussy has suggested percussion over the spinous processes of the cervicle vertebra in the course of the trachea. Following this line in healthy subjects a distinct tubular sound is elicited by percussion down to the point of bifurcation of the trachea; at the level of, and opposite the fifth and downwards we get the lower pitch and pulmonary resonance.

When the trachial or bronchial glands are enlarged, the tubular sound over the upper dorsal vertebrae is replaced by dullness, which may contrast sharply above with the tracheal, and below with the vesicular resonance. The result of bronchial pressure upon the pulmonary tissues is best marked when the processes of phthisis are not too extensive, also in interstitial phthisis, or in cases where there is marked bronchial complication. In these cases the lumen of the bronchi are seriously diminished, and vescicular air supply is interfered with; consequently, emphysema with or without asthma atelectasis or a very intractable bronchitis may occur. I will not describe the morbid process

of phthisis in detail. The involvment of an entire lung is simply the filling up of the parenchyma with peri-bronchial product or with the results of the desquamative pneumonic or interstitial process. And as one or the other of these predominate so do we have peri-bronchial, fibroid or catarrhal phthisis. Another interesting although not demonstrable incident in the pathology of phthisis is hæmorrhage. Bleeding from the lungs occurs both early and late in the history of cases. The hæmorrhage is easy to explain, being nearly always due to ulceration of the blood vessel walls. The cause of early hæmorrhage is less simple; it is possible that in cases of phthisis there may be mal-nutrition or fatty degeneration of the blood vessel walls, rendering rupture under conditions of increased arterial tension in the lungs an easy circumstance. It may also be the result of tubercular infiltration of the muscular walls which is followed by rupture of the blood vessels. Cavities in phthisis are the result of several processes. They occur by (*a*) a slow or rapid process of fatty degeneration, followed by ulceration; (*b*) as the result of chronic bronchitis, and softening of bronchial tissue, with subsequent yeilding to traction from without; for instance in broncho-pneumonia, or fibroid phthisis; (*c*) abscesses as a sequence of acute lobular-pneumonia following hepatization or purulent infiltration; (*d*) as the direct result of gangrene, itself the immediate consequence of wounds of the lungs or blood poisoning, or of emboli. Local gangrene on a small scale occurs sometimes around cavities in lungs, or in the bronchial tubes, and may give rise to temporary fetor of breath, but is not likely to lead to fallacious inferences, chiefly because of its temporary character and the absence of permanent concomitant symptoms. It naturally follows that there are two locations for vomical, the pulmonary and bronchial tissues. Specimens illustrating the various forms of cavities are upon the table.

The limits of a paper designed to open a discussion on phthisis will not permit me to dwell upon the bearing of these pathological changes upon physical diagnosis; I therefore will close with a brief resumé of the general clinical symptoms which define the diagnosis of the various sorts of cavities: *Phthisical Cavities*, commonly are situated in one or both lungs, and are indicated as a development in a train of spmptoms which include as prominent features, gradual emaciation, persistent loss of weight by reason of mal-assimilation of food, more or less frequent hæmorrhage,

and hectic, frequent pulse, hacking intermittent cough, numular sputa, expectorated in varying amounts throughout the twenty-four hours, and not periodically as in bronchial dilatations, nor is augmented by a gush of pus and mucous as in abcess. *Cavities of the Nature of Abcess.*—The pathology of these cavities, with its coincident clinical history, is not that of phthisis. The history of these cavities is either recovery by contraction (especially after wounds) or more frequently the abscess grows larger and larger until the entire lung may be destroyed, in this respect resembling phthisical cavities. When death occurs it is by exhaustion and hectic, where recovery takes place it is by free opening externally or internally, and evacuation of the contents. At times the small amount of constitutional disturbance, slight degree of emaciation, good pulse, easy breathing, slight cough and healthy complexion are in noticable contrast with the physical sighs. Cavities of the nature just described are mostly located in the base of the lungs. *Cavities due to Bronchial Dilation*—Frequently for years the general health is almost unimpaired, and it is never so proportionately to the degree indicated by the physical signs. There is no hæmorrhage nor night sweats, and emaciation is not a pronounced symptom. The same physical signs persist for months or years unchanged, contrary to the history of most phthisical cavities, which continually alter with the advancing malady. The expectoration of bronchial dilatation is more abundant, fluid and purulent, than in catarrhal phthisis, and is usually brought up in the morning, or evening by the cupfull. It is not a constant spitting of numular sputa, as in true consumption. In chronic cases the expectoration may become so fetid as to generate suspicions of gangrene; the cough is harrasing, but is often relieved if the bronchial cavity is thoroughly emptied.

Dr. Musser said that little could be added to this admirable and concise, yet exhaustive resumé of Dr. Bruen on the morphology of phthisis. The limited experience that he had had in the study of the histology of phthisis had convinced him that in the microscopical structure of the lesions, there is but little difference noteworthy in the primary changes. We have one school teaching that inflammation, another that tubercle is the primary element I cannot but agree with the author of the paper in the statement that the disease varies histologically with the varience in the intensity of one of these elements. In both we have epithelial proliferation and accumulation, changes in the vascular and lymphatic tis-

sues (tubercule) and increase in the interlobular connective tissue. So intimately is the evolution of each of these processes connected that a classification like that of Grene (*Lancet. 1882*) seems most proper (*a*) Consolidation. Intra-alveolar. (*b*) Consolidation involving mainly alveolar walls. (*c*) Consoidation consisting largely of intra-lobular connective tissue. Without absolute commital either way, and yet in the line of exact truth the distinction thus given seems to cover the entire histological ground. Dr. Musser has had abundant opportunity for the study of the clinical aspect of phthisis and althongh an arbitrary histological distinction of its varieties cannot be made, it is of the utmost importance as influencing treatment and hence the prognosis of the case to have a distinct and definite idea of the clinical varieties. The importance of the subject will be sufficient apology for the clinical remarks. Ante and post-mortem observation has led him to adopt the following classification, as convenient, systematic and embodying the various phases of the disease.

Acute.

A. 1. Catarrhal pneumonia.
2. Pneumonic or caseous phthsis.
3. Pulmonary tuberculosis.
4. Miliary tuberculosis.

B. 1. Catarrhal pneumonia. Tubercle may be seconary.
2. Tuberculosis.
3. Interstitial or fibroid phthisis. Tubercle may be secondary.

It is scarcely fair or proper to call acute catarrhal pneumonia a kind of phthisis, as it only is related as a possible primary factor. So seldom is it recognized and so baneful are the results of non-recognition, and hence inactive and inadequate treatment, that it is important to show its relation. It will be observed that catarrh and tubercle are distinguished, and so for *convenience* and *contrast* we may term the kinds "catarrhal" and "tubercular." Perhaps a clue to the pathology of phthisis may be found in defining the characteristics of each. In the first place there is a marked difference in the predisposing causes of the disease—hereditary and diathetic condition. Thus tubercular phthisis is markedly hereditary, catarrhal is not; the tubercular is associated with tubercular diathesis and a phthinoid chest, the catarrhal, in some with scrofulous diathesis and a perfect chest. Then the mode of onset differs greatly. In the former the general symptoms are more marked, the pulmonary symptoms in abeyance; in the latter, the pulmonary symptoms are more marked, the general slight. Emaciation, loss of appetite and dyspepsia precede or accompany the development of the former; they do not occur until late in the latter,

Amenorrhœa and changes in the voice also occur early in tubercular phthisis. In tubercular phthisis hæmorrhage occurs more, frequently and earlier than in catarrhal. In tubercular phthisis dyspnœa is a more marked and early symptom, and is out of proportion to the physical signs. Debility is more marked and more readily induced in tubercular phtisis.

The temperature is not so hig hearly, and does not have the long daily sweeps in the late stages, in tubercular as in catarrhal phthisis. With a doubtful mark, it seems pleurisy, and chest-pain is more common and constant in the tubercular than in the catarrhal form. The physical signs are bilateral and not pronounced in the tubercular form; they are unilateral and pronounced in the catarrhal form. The progress of the tubercular form is rapidly and progressively downward; of the catarrhal, slow and in spurts. Tubercular phthisis is contagious? and ante-infective. Over and over again do cases present themselves at the University Hospital and Dispensary with just such definite and broad distinctions, which distinctions should determine the line of treatment to be adopted, the catarrhal form requiring a more active local and general antiphlogistic treatment. It is not to be forgotton that the cases are not always, I may say generally, so easily distinguished, while the picture does not apply to acute miliary tuberculosis or fibroid phthisis. In a previous discussion on phthisis, Dr. Musser had held that acute primary plastic pleurisy did not occur save in a tubercular subject, and hence was secondary to that diathesis. That statement is possibly too broad, and it should be that frequently recurring acute pleurisies occur only in the tubercularly diathetic, and are antecedent to the development of phthisis. The recognition of exocardial and subclavian murmurs lead one to say than persons having such sounds are *threatened* with phthisis. Dr Eskridge said that he had been much interested in Dr. Bruen's remarks, in most of which he concurred. As to pleurisy antedating phthisis, it was an old view, which had lately been revived. He had been struck with the frequency of chest-pains preceding phthisis; in over seven hundred cases of which he had notes, this symptom was noticed in more that two-thirds. This pain may be on the opposite side to that of the affected lung. Interstitial phthisis is not always a chronic affection, Dr. Barlow and others having reported cases which proved fatal in six months. Hæmorrhage,

in his experience, was a very common symptom in this variety of phthisis.

Dr. Eskridge called attention to the fact that cardiac valvular diseases, especsally mitral regurgitation, attended by venous congestions and coming on after birth, are rarely associated with phthisis; while congenital deformities of the heart, attended by venous stasis, etc., are followed, according to some eminent authorities, in nine-tenths of the cases, by tuberculosis of the lungs. Dr. Shakespeare said that one point made by the lecturer had especially struck him as being opposed to his own experience, viz., that the earliest part of the lung attacked was generally the root. He had usually found the consolidation at the periphery of the lobe, often forming, as it were, a shell of sodid lung perhaps an inch thick, while the central or deep portions would be either not at all, or but little affected. This peripheral consolidation seemed to have no particular relation to initial pleurisies, for the consolidations were quite frequently met with in cases almost free from pleurisy and old adhesions. He had also very often noticed at autopsies after death from intercurrent diseases, wedge-shaped patches of solidified lung tissue, having the base at the perphery of the organ and a slightly raised surface, much like infarcts and containing miliary tubercle whilst the intervening pulmonary tissue was normal.

Dr. Formad asked Dr. Bruen what he considered was the difference in the pathology of acute and chronic phthisis? Also on which side the disease most commonly occurred? Dr. Formad also desired put on record, some observations on the histology of phthisis, made by W. H. Mercer in the Pathological Laboratory of the University of Pennsylvania, which he narrated as follows: that acute phtisis (all fatal cases) is invariably complicated with crupous pneumonia, which conditions the lethal termination, that the lining of the broncholes and the endothelium of the blood vessels plays a very active part in the formation of organized tubercle granulations, filling and widely distending the lumena in both instances. The existing observations on this point as far as I remember, refer only to blood vessels, and then merely to cheesy, broken down material obliterating vessels, or occasionally to the formation of giant cells, or to something which in transverse section similates a giant cell. Mr. Mercur states that the obliteration of broncholes by living, organized granulation tissue is the most common starting point

for pulmonary tubercle granulations, and forms the greater bulk of the latter. He also found that the exudate within the air-vesicles in acute phthisis, was capable of undergoing complete organization, and that a group of such blocked up air-vesicles with organized exudate is usually called (erroneously) a miliary tubercle, the outlines of the air-vesicles being mistaken for sub-miliary tubercles. Mr. Mercur had failed to find a single true miliary tubercle in a large number of thoroughly studied cases of phthisis, and agrees with those who regard miliary tubercle nodes as secondary products only. Dr. Formad desires distinctly to state that Mr. Mercur's observations were made on, and apply only to the lungs.

Dr. Tyson was interested to note how much histological investigations has contributed to our knowledge of the nature of these important processes under discussion; and while he was ready to admit that we owe much to experimental pathology, he felt that our present more correct notions were the result of microscopic studies of the human tubercular lung. The point to be insisted upon is that all these processes are tubercular and all are inflammatory, the catarrh of the lung and tubercle granulations being in all cases the initial lesion, whence it extends peripherally by desquamative catarrhal pneumonia or centrepetally by a tuberculous peri-bronchitis, the former furnishing the rapid and the latter the slow forms of phthisis. That pleurisy is often the initial lesion of tuberculosis, he thought, had long been acknowledged. Dr. Shakespeare said that the observations reported by Dr. Formad for his pupil, reflected great credit upon both and was another testimony of the value of the work done in the pathological laboratory of the University, but at least two of the announcements, for which novelty and originality were claimed, had been forestalled years ago, by other observers. He had particular reference to the organization of the products within the alveoli of the lung and the announcement that the walls of the minute blood vessels, by a proliferating endo-arteritis and peri-arteritis formed the miliary tubercle. The former is not only recognized and described in Green's Handbook of Pathology but also most beautifully *illustrated*. The latter has been repeatedly observed and published, sometimes with illustrations. This origin of tubercle is distinctly referred to in the text-books of Wagner, and Cornil and Ranner. All these books are in the hands of the University students.

Dr. Formad said that existing observations on this point, as far as he remembered, referred only to blood vessels, and then merely to cheesy, broken down material obliterating the vessels, or occasionally to the formation of a giant cell, or to something which in transverse section, simulates a giant cell.

In closing the debate upon the subject, Dr. Bruen said that he had coincided with Dr. Tyson in the opinion that phthisis was rarely associated with heart disease. In mitral regurgitation there was often indeed a thickening of the pulmonary substance allied to the indurative changes in the other organs from like causes. Advanced fibroid disease, with cavities as shown in one of the specimens exhibited by him through the kindness of Dr. Hinsdale, he had not met with heretofore. Dr. Formad's query as to the relative frequency of phthisis upon the right or left side, he felt must be answered by the statement that one side was as liable to disease as the other, while probably, in a small majority the right side was most frequently involved. He thought that the peripheral portions of the apices anteriorly was the most common starting point, where there was much degenerative pneumonia and rapid phthisis, while the roots posteriorly were primarily attacked in the more slowly developed forms of broncho-pneumonic phthisis. The roots of the lungs are the seat of the latent phthisis developed as the sequential lesion of croupous pneumonia. Dr. Bruen dissented from the view that croupous pneumonia was a frequent cause of death in phthisis. He believed that in the rapid, as well as in the more latent form of phthisis, death was preceded and hastened by a development of the tubercular nodular tissue to which allusion had been already made. This tissue completely fills up and chokes the mucous pulmonary structure causing dyspnœa, etc., etc.

C. B. NANCREDE, Sec.

Clinical Reports from Private Practice.

Article XLII.

"The Blue Man of Missouri."—The Effect of Nitrate of Silver on the Skin and Mucous Membrane.—Reported by Thos. F. Rumbold, M. D.

Mr. J. S. F———, æt. 33 years, of Columbus, Mo.—At the age of about fifteen years he took daily from five to ten drops of a solution of nitrate of silver of the strength of grs. xx ad. ℥j. This was continued for about five or six months; at the end of this time he noticed that his face and hands were getting a peculiar dark color. The color increased for some time after he discontinued taking the silver solution.

The color of the integument of his face and hands at the present time resembles a No. 2 lead pencil mark, with a light sky-blue in it. A stove merchant, who happened to see him in my office, thought that his face and hands had the appearance of being colored with a light coating of stove polish, which is really a very good description of his appearance, as the skin of the face, especially, has a marked polished appearance or a shine to it. The color is decreased during cold and dry weather and increased during damp and hot days.

The mucous membrane lining the anterior nares, the inside of the mouth, the lips, the under portion of the tongue, the soft palate, tonsils, pharyngo-nasal cavity, larynx and vocal cords were all colored by the nitrate of silver, so were also the membrana tympana and the sclerotic coat of the eyes.

The whole of his body was more or less colored, but not to so marked a degree.

Correspondence.

Article XLIII.

QUACKERY.

Editor Journal:

In our endeavors to stear clear of quackery, we are not sure of escape, if we judge the physician by his accomplishments.

Some of the most dangerous characters in this respect, posses high mental culture and polite demeanor. Captivating their dupes by these very means. Neither is it the one who knows little of therapeutics, physiology and pathology, most to be feared.

The unlettered bigot and the conjuror may be styled quacks, yet we are not annoyed in our profession, to any great degree, by the grossly ignorant. The very possession of a sharp intellect, genteel manner, literary knowledge and medical skill, enables him who would enter the rôle, to take position behind them, like the soldier under cover of fortifications.

Such a one will ply his work when in consultation, and appear in superior grandure, when compared to another who aims to be professionally correct. He impresses the patient and friends with almost worshipful approval. There are many grades in quackery. The doctor who does by another physician, different to the way he wishes to be done by, is a quack.

The doctor who prescribes patent medicines and puts up compounds of his own for sale, is a quack. The doctor who will not meet in counsel with any one else for fear of lowering himself, is a quack. We have yet another kind of a quack. Take a seat in the average drug store and observe; in course of events a customer enters, saying, "I am unwell," and making inquiry of the clerk, "Do you think you have anything that will relieve me?"

Said clerk inquisitively answers, "Well, what seems to be the matter, how do you feel?" A rude description of his feelings is given by the sick man.

The druggist thinks of the printed directions on some of his medicines recommended for similar symptoms,—"Certainly, I

think so, yes," he answers; and the drug is handed over the counter, the money taken, and caution given to follow directions.

The man's ailment may be one disease or it may be many; it makes no difference, just so he can name it or suggest how he feels—the remedy is forthcoming.

Here we note two evils in the one transaction: First, the sick man does not know why nor how he is diseased. Second, the druggist does not know what the medicine is he has prescribed. The patient, in his ignorance, supposes the clerk should know the uses of his drugs; and the druggist, on the evidence of printed indications, and complaints made by the sick, blindly gives the medicine.

This druggist, if asked by a patron of yours, "Can I get more of the medicine that Dr. P. told me to get here when my wife was sick," will go to the file of prescriptions, hunt out the formula, put up the remedy and place on the bottle, written directions over your name.

There are few druggist who do not prescribe in this way; and in my judgement it is the most formidable species of quackery, the honest practitioner has to encounter. Again, it is a custom among druggists to furnish physicians with prescription blank books. And on the margin of each leaf, are printed the names of some of the principal article on sale at the place of trade, and the name of the firm, with instructions to take the order to said firm. If you write a prescription on such a page, you become an agent for the sale of the articles advertised, and direct your patron to go tothe vender to make his purchase.

No physician who understands his duties and has the proper regard for his patients, will ever prescribe a patent medicine, neither can he afford to become agent for it. I am almost persuaded the time is near at hand when we, of necessity, will be compelled to dispense our own drugs, and thus obey the first law of nature.

T. HODGE JONES, M. D.

ARTICLE XLIV.

EDITOR JOURNAL:

I have just read in the March No. of the JOURNAL, what Dr. Stevens had to say in regard to Swedes and Norwegians drinking alcohol, in the pineries of Wisconsin and Minnesota. I practiced medicine thirteen years in Northeastern Iowa. There was a large settlement of Norwegians in my circuit, and I corroborate what Dr. Stevens says in regard to their drinking alcohol.

This is their common drink and every family keeps it in the house and drinks it as freely as the Germans do their beer. I have seen but few cases of tremens, and not so much drunkeness as I have seen among the railroad Irish with their rot-gut whiskey. The class of Norwegians in Iowa, are the very poor in Norway. They manage to get enough together to get over here, and with their simple wants and frugal habits, very soon get rich. In harvest, where great exertion is required, they drink their alcohol freely; have it in the field with them, and they all work in the field then; women, children and all use the alcohol freely.

I have scarcely ever seen any drunk at these times. I saw a great deal of phthisis among them, and their remedy is their alcohol and their native cod liver oil, with a kind of domestic beer they make out of barks &c., they import from Norway. I saw more consumption among them than I ever saw among other nationalities. Probably the reason is what I have already stated, they are the very poorest class Norway has, hence, bad food and scant supply,—poor in quality—etc., engender it.

I have often been led to think of the different kinds of stimulants and narcotics the human family uses. Every nationality has its stimulant and narcotic. As above, the Norwegian and Swede, his alcohol; the German, his beer; the Irish, his whiskey, etc. But what does the American drink? We are a mongrel nation, hence, our drink is a mongrel drink—a little of everything.

The Chinaman will do more on his stimulating doses of opium, standing it longer and harder than any of these national

alcohol drinkers will. I was acquainted with an intelligent Chinaman who would endure twenty hours out of twenty-four, and hardly show fatigue, on small doses of opium.

I myself have ridden day after day—when it seemed as though I could hardly climb into my buggy without it—on *strong coffee*.

A book might be written on the judicious use of stimulants, taken as *food*, and perhaps in a short time I will prepare a paper on stimulants and narcotics, from this standpoint.

Yours Respt.,

DR. N. A. DRAKE.

Kansas City, March 22, 1882.

Editorial.

Article XLV.

SANATIVE CONDITION OF ST. LOUIS.

Small-pox has again made its appearance in St. Louis. For some time past the officers of the Health Department have been renovating and preparing the Quarantine Hospital, and just when everything was in readiness for patients, the patients arrived.

Within the past week, fifteen to twenty cases of small-pox have been found in the city; the cry that *small-pox is in the city*, would not cause so much apprehension if it were not for the fearful condition of our streets; all winter the mud and filth has been accumulating, and there has been but a weak attempt on the part of the Street Commissioners to remove it, and although our papers and journals have kept up a continual ding-dong on the subject, and the importance of clean streets in relation to public health has repeatedly been pointed out to them, still they have paid but little attention to it.

When warm weather comes, the scent that will assail one's nostrils, will simulate the peculiar odor that is smelt in the city on the lakes, when the wind is up river.

In the present condition of the streets, they must be very deleterious to public health, and in the event of yellow fever or cholera making its appearance, St. Louis will most certainly get her share of these diseases.

In all the public streets, the mud and filth ranges from two inches to six and eight inches deep, and in some of the heavily traveled streets, the slush lies twelve inches deep, while the alleys are filled with ashes and garbish, and it has been truly said of St. Louis, that while she has a solid financial basis, she is one of the dirtiest cities in the Union.

THE COLLEGE FOR MEDICAL PRACTITIONERS.

This College has finshed its Second Course and will, on the 7th day of May next, commence its *Third Course*.

This is an institution in which every physician in the West is interested. In it they may acquire further knowledge, to enable them to more successfully practice their profession. A College so entirely new in all its working plans as this one is, require some time to perfect its organization. The working plans required for an ordinary medical college, are well known; but those of an institution of this kind can only be ascertained by trial. To know what is most required by those practitioners who are most likely to attend, canonly be found out by consulting the wishes of several classes. We all know what the most ignorant physician requires, but this *genius* will not attend our College, as he has not got the money, nor has he ambition to do so.

While there is no scarcity of those who are fully able to teach *non-graduates*, there are few who are both able and willing to undertake the instruction of Medical Practitioners are determined to keep abreast of the profession, some of whom have had from ten to thirty years experience in practice, consequently are well informed on some of the most important subjects of medicine. To teach non-graduates, requires but little more than that the text-books be memorized; but to teach a class composed of experienced and reading physicians, requires the combination of large experience, full information on *all* the latest views of the most advanced of the profession and an aptitude to impart what they know in a manner that will be attractive to the hearers and will be retained by them.

The expectation of its founders to give satisfaction to its students, is fully realized as the resolution passed by them, at the last course plainly attests. At their request, this is placed before the readers of the JOURNAL.

COLLEGE FOR MEDICAL PRACTITIONERS,
St. Louis, 1225 Washington Ave.
March 6, 1883.

The medical class of the above College, assembled this day and elected Dr. P. W. Logan, of Stanford, Ky., Chairman; and Dr. O. B. Hicklin, of Elk Lick Springs, Mo., Secretary.

The Chairman briefly stated the object of the meeting and on motion appointed a committee composed of Drs. J. E. Bahrenburg and D. A. Ostertag both of St. Louis, to draft a preamble and resolution, expressive of their high appreciation and esteem for the Faculty of the College.

The Committee reported the following:

In as much as we feel very grateful and are under many obligations to the Faculty of the COLLEGE FOR MEDICAL PRACTITIONERS for many favors shown us, we offer the following resolution as an expression of our appreciation of their enterprise in the establishment of this College.

Resolved: That we fully appreciate the many good results that have accured to us during the past five weeks, and recognize the fact that *a school for practitioners is a desideratum* that cannot well be supplied except by a school of this kind, which is entirely unique in its character. The lectures have been instructive, practical and interspeiced with the exhibition of many important and interesting cases of a surgical and gynæcological character. We have also had access to the College Dispensary every day, where we not only had the pleasure of seeing a multitude of patients afflicted with the various diseases of the nose, throat and ears, but were permitted to treat them in accordance with the most recent and approved plans, thereby being enabled to handle instruments with more dexterity and skill than we otherwise could do. In fact every department of medicine and surgery, both special and general has been represented in a manner entirely satisfactory. We therefore feel that this testimonial is due the Faculty, and hope that they will accept the same as an evidence of our gratitude and an endorsement of their method of teaching, and request that this action on the part of the class be published in the ST. LOUIS MEDICAL AND SURGICAL JOURNAL.

The above being unanimously adopted, the meeting adjoured.

O. B. HICKLIN, M. D,

Sec'y.

News Items.

Article XLVI.

The quarterly meeting of the Illinois State Board of Health will be held in Chicago, April 12th, at the Grand Pacific Hotel. At this meeting the annual examination of non-graduates will take place.

The Association of American Medical Editors.—The next annual meeting of the Association of American Medical Editors will be held in the City of Cleveland, Ohio, simultaneously with that of the American Medical Association, on June 5th and 6th, 1883. The order of exercises for Tuesday, June 5th, the session opening at 7.15, P. M. will be as follows: Roll call; reading of minutes of previous meeting; address by president and discussion thereon; reports of committees; deferred business; new business, election of members, adjournment. The programme for Wednesday, June 6th, the session opening at 7:15 P. M., will be as follows: Roll call; reading of minutes of previous meeting; address by Dr. Henry O. Marcy, of Boston; reading of special papers by Dr. John A. Octerlony, of Louisville, Ky., and Dr. Alexander J. Stone, of St. Paul, Minn.; discussion of addresses and papers; reports of committees; deferred business; new business; election of officers and members; adjournment. The subject of the address to be delivered by the president, Dr. N. S. Davis, Chicago, is: "The Present Status and Tendencies of the Medical Profession and Medical Journalism." A free discussion upon this important subject is invited, which will be open, not only to members, but to all physicians present. Dr. Marcy's address will be upon the subject of: "Journalism devoted to the Protection and Concentration of Medical and Surgical Science in Special Departments." The secretary was authorized at the last meeting of the Association, held at St. Paul, Minn., to make the above arrangements for the coming meeting, and also to specially invite all the members of the profession, and friends attending the meeting of the American

Medical Association, to be present. The meetings will be held in the intervals between the meetings of the sections of the American Medical Association, and the social entertainments of the evening. The sessions will be short and undoubtedly interesting.

Very Respectfully,

J. V. Shoemaker, M. D., Sec'y.

From the new edition of Messrs. Geo. P. Rowell & Co's American Newspaper Directory for 1883, which is now in press, it appears that newspapers and periodicals of all kinds issued in the United States and territories now reach the imposing total of 11,196. This is an increase of 585 in twelve months. It is interesting to note that the newly-settled regions of the Canadian Northwest are productive of newspapers as well as wheat, for the number of journals issued in Manitoba was nearly doubled during the year.

The corrigentia used at present to disguise the odor of iodoform are not satisfactory. For this reason it will be of interest to know that carbolic acid is an excellent corrigent. Add .05 carbolic acid to 10 grm. iodoform, and the odor is entirely covered, and it does not return even at the highest temperature. Two drops of ol. menth. pip. added to the powder increases the pleasantness of the odor. In ointment this powder thus prepared is far preferable to the odor produced by tonka bean, bals. peruv., ol. carui, or ol. menth. alone. It is always advisable to rub up only so much of the acid carbol. in the powder as the above formula calls for, as a greater quantity would in many cases prove irritating.—[*Berlin Klin. Wocken-script*, No. 48, 1882. Carl Scherf.

Salicylic Acid in Night-Sweats.—The following powder is recommended by Dr. Könhorn in the night-sweats of phthisis: Acid salicyl. gr. 45, starch, ʒ ijss, chalk, ℥ ijss. The entire body of the patient is dusted with this powder at bedtime. The author claims to have obtained great success by this treatment. The same powder is employed in the Austrian army in sweating off the feet.—[*Memorabilien*, Nov. 15, 1882.

Remedies for Headache.—The following recipes and sug-

gestions for the treatment of different forms of headache are collected from a variety of trustworthy sources:

Two grains of citrate of caffeine, in capsule, taken every half hour, is a very effectual remedy in nervous and sick headache. One or two doses are often sufficient to give complete relief. The only objection to its use is sleeplessness, which sometimes result if it is taken in the evening. It is preferable to guarana as being hardly ever rejected by the stomach.

The following, according to Dr. W. W. Carpenter, is very effectual in most forms of headache:

Muriatic amonia, 3 drachms; acetate of morphia, 1 grain; citrate of caffeine, 30 grains; aromatic spirits of amonia, 1 drachm; elixir of guarana, 4 ounces; rose water, 4 ounces. Mix. Dessert spoonful every ten or twelve minutes.

In nervous headache, Dr. W. A. Hammond states the value of various drugs as follows:

Oxide of zinc is of great value. Ordinary dose, 2 grains, three times a day, after meals; the maximum dose, 5 grains. It is best given in the form of pills.

Nux vomica is preferable to strichnia. The dose is ¼ grain, after meals. If the patient be chlorotic, it is well to combine a grain of reduced iron and a half grain of sulphate of quinine.

Bismuth in the form of subcarbonate, will often take the place of oxide of zinc. Dose, 2 grains, after each meal. Bismuth probably aids digestion more than any mineral tonic, and is of use where there is gastric disturbance.

The bromines are servicable when the nervous system has been irritated; when it is exhausted they do harm.

Phosphorus is very useful in most forms of nervous headache. The best results are obtained from dilute phosphoric acid, in doses of 30 drops, largely diluted, three times a day, after eating, or phosphide of zinc, .1 grain, in pill three times a day.

Arsenic, as a nerve tonic, stands next in value to zinc. Dose, 5 drops of Fowler's solution three times a day, after meals.

Galvanism is sometimes valuable, but by no means a specific. The constant current should always be used, being careful to avoid too great intensity, lest amauosis be produced.

Dr. T. Lauder Brunton, editor of the London Practitioner, says: The administration of a brisk purgative, or small doses of Epson salts, three times a day, is a most effectual remedy for

frontal headache when associated with constipation; but if the bowels be regular, the morbid process on which it depends seems to be checked, and the headache removed even more effectually by nitro-muriatic acid, diluted 10 drops in a wine glass of water, or bicarb. soda, 10 grains, in water before meals. If the headache be immediately above the eyebrows, the acid is best; but if it be a little higher up, just where the hair begins, the soda appears to be the most effectual. At the same time the headache is removed, the feeling of sleepiness and weariness, which often leads the patients to complain that they rise up more tired than they lie down, generally disappears.

A writer to the London Lancet remarks: At the Middlesex Hospital, female patients who have suffered many years from sick headache, evidently of a hereditary character, have been greatly benefited, if not cured, by the administration of 10 minim doses of tincture of Indian hemp, three times daily before the attacks. This is well worthy of trial in those cases of ever-living, never dying, martyrdom-like suffering.—[*Hospital Gazette.*

Marriage and the Microscope.—The extremes to which microscope cranks are liable to go receive an apt illustration in the following, quoted from Heitzmann's Microscopical Morphology:

Marriages should be allowed, in doubtful cases, only upon the permit of a reliable microscopist. Last season a young physician asked me whether I believed in the marriage among kindred. He fell in love with his cousin and so did his cousin with him. I examined his blood and told him that he was a "nervous man, passing sleepless nights, and had a moderately good constitution. The condition being suspected in the kindred lady, marriage was not desirable for fear that the offspring might degenerate. So great was his faith in my assertions that he gave up the idea of marrying his cousin, offering her the last chance, namely, the examination of her blood. The beautiful girl came to my labratory and, very much to my surprise, I found upon examination of her blood a first-class constitution. The next day I told the gentleman, "You had better marry her."—[*Medical Age.*

The Qualifications of a Health Officer.—The following deffinition of a successful health offier, copied from the *Medical*

News, of Philadelphia, is respectfully submitted to the consideration of appointing powers wherever found:

The rapid advance in sanitary knowledge, and as a consequence, the more exacting demand for a careful and wise administration of sanitary law, requires a rigid scrutiny into the qualifications of all executive officers of health. So varied and responsible are the duties entrusted to the health officer of a large town or city, that without special knowledge and training and good administrative ability, the holder of the position cannot successfully discharge the obligations of the trust. Recognizing the soundness and wisdom of this principle, the local government of England has long since required that all health officers shall be medical men, who, by education and training, are especially fitted for the work of investigating the causes and prevention of diseases, the management of epidemics, supervision of sanitary inspections and the intelligent administration of the laws of health.

It happens too often in this country that the position of health officer is one of political reward without consideration of personal and professional qualifications. The result is an inefficient, haphazard and automatic execution of the laws, and a failure to judiciously and efficiently carry out the duties of the office through ignorance of the fundamental principles of public and private hygiene.

A health officer should be an experienced sanitarian and a physician of thorough education. He should be capable of advising the sanitary authorities in all matters affecting the health of the people, and he should be competent to intelligently inquire into the cause, origin and distribution of diseases to ascertain to what extent they are capable of removal or mittigation, and to make use of all the means at his disposal for the preservation of the public health. He should give his entire services to the position; he should receive a liberal compensation, and should have the assurance of remaining in office so long as the duties of it were judiciously and efficently discharged. The present uncertain tenure of office is a bar to an eligible appointment, as none but a professional office-seeker is willing to throw aside the advantages of a permanent avocation for an office of uncertrin tenure.

Iodoform as a Vermifuge.—Dr. Schildowsky (St. Peters-

burgh Med. Woch.) has found that iodoform is destructive of round worms in the intestines. He has employed it successfully in three cases, and with results which warrant him in asking for it a further trial. The adult dose as given by him is 1 grain, with 10 of bicarbonate of sodium; for a child the dose must be reduced in accordance with the usual rule.

A prince of science having been called to see a sick child, prescribes for it, and on his visit the following day is surprised to find the family in tears. "My poor child," sobs the mother, "I never thought he would have died of croup." "Of croup!" echoes the doctor, "do you mean to say the child died of croup? Why didn't you tell?"—[*Medical Age.*

Transplantation of Muscle in Human Beings.—Before the Imperial German Congress of Surgery, Herr Helfrich read a on this subject (*Medical Press and Circular*) based on a case in which the whole of the biceps of a woman had been removed, with the exception of a strip the thickness of a lead pencil and replaced by a piece of muscle from a dog. Complete healing took place, and after some months' use of electricity the power of movement lost previously to the operation was restored Herr Gluck (Berlin) reported that his experiments in transplantation of muscle had always given positive results.

Dialyzed Iron.—Dr. Prosser James has lately said, in a summary of the position which dialyzed iron is entitled to hold in medicine, that the persalts of iron are frequently employed solely on account of their astringency, while the protosalts are occasionally considered as being destituted of this quality. The freshly-prepared carbonate is an excellent mild chalybeate, bnt difficult to keep in an unaltered state, so that preference is given to reduced iron. The scale preparations of iron are held in repute, both from the extreme facility of their use, and their agreeable taste. When these three forms of iron are inadmissible, dialyzed iron may be resorted to with admirable effect. It is a milder chalybeate than the three preceding, and does not produce the slightest irritation.

A recent analysis by Professor Tichborne of Wyeth's preparation agrees almost exactly with Graham's statement, that dialysed iron contains 98.5 parts of the oxide and 1.5 parts of

hydrochloric acid. The liquid thus obtained differs altogether from an ordinary solution of salts of iron, by its not giving rise to the blood-red color on the addition of alkaline sulphocyanide, nor to the blue precipitate with ferrocyanide of potassium. It does not become cloudy on boiling, nor when agitated with two parts of ether and one part of alcohol is the ether layer colored yellow. It is so sensitive that ordinary spring water will cause a precipitate, yet no precipitate is produced by nitric, acetic, or muriatic acid. Graham's solution gelatinized in about twenty days, and he regarded it as a solution of colloid ferric hydrate which, he cosidered, existed in both a soluble and insoluble form. It is however never free from chlorine. Theoretically, therefore, the liquid is a solution of a basic oxychloride, but it can nover be imitated by dissolving saturated solutions of the hydrate. All these artificially-made liquors are astringent, with ferruginous taste and acid reaciion.

Respecting the therapeutic value of dialyzed iron, of which there has lately been some inclination to doubt, Dr. James says there is no qnestion. By the method now followed of counting blood-corpuscles, it is found that the taking of dialyzed iron both increases their number and improves their condition. Dr. James gives, as an average dose, twenty to fifty drops, daily, in three doses. Dr. Weir Mitchell, of Philadelphia, gives as much as a drachm at a time.

Specimens have appeared in the market which are not only innocent of any acquaintance with a dialyzing membrane, but seem ltle else than diluted solution of perchloride of iron.—*London Chem. and Drugg.*

A HALF glass of very hot water, taken morning and evening, is said to be an American panacea lately introduced into England as a "pick-me-up." It has been found especially valuable in gout, rheumatism, indigestion, dyspepsia, etc., as occurring in those whose brains are habitually heavily taxed.—[*Ibid.*

MEDICINE AND LONG LIFE.—An analysis of the tenth census of the United States with especial reference to doctors of medicine shows that the number of doctors in 1880 was 87,671, of whom 2,432 were women. Of this number, 8,397 were over sixty years of age. This is a better showing than is made by any of the other occupations of men, the clergy alone excepted. It cor-

roborates that made by the profession in England. It is a somewhat significant fact, moreover, that the largest percentage of aged physicians is found among those who have been prominent in the calling, their brain work performed by these evidently, as in the case of clergymen, being favorable to longevity. Among twenty English physicians whose ages were recently published, and the average of which was a fraction over 85 years, there was not one who had not attained prominence. The conjoined physical and mental exercise necessitated by the practice of medicine more than offsets the evils due to exposure and irregular hours.—[*Medical Age.*

Well, madam, how's your husband to-day?" "Doctor, he's no better." "Did you get the leeches?" "Yes, doctor, but he could only take three of them raw; I had to fry the rest.

Snake Bites.—Dr. J. T. High recommends for this purpose ammonium carbonate, and he says:

"Split the skin where the fangs entered, insert the ammonia, also give fifteen to twenty grains every hour, dissolved in water, and he will have no further trouble. I live in a snake country, and have used the remedy with satisfaction."—[*Drug News.*

Coffee in Typhoid Fever.—*Medical Times and Gazette.*) In the early stages of typhoid fever, Dr. Guillassee, of the French Navy, has administered coffee with marked success. Three teaspoonfuls are given adults every two hours, alternating with one or two teaspoonfuls of claret or Burgundy wine. A beneficial result is immediately apparent. A little lemonade or citrate of magnesia is also administered daily, and after some time quinine is recommended.

Vaccination Accidents.—A woman in Crawfordsville, Ohio, accidently touched a sore spot on her lip with a finger on which there was a small amount of vaccine viris. Her face and neck began swelling, and her condition was at first critical.

A man in Colfax sauntered into one of the drug stores there and seeing some vaccine points on the counter, mistook them for toothpicks, and proceeded to utilize one of them as such. His mouth became very sore, and it was feared that the consequences of this unusual method of vaccination would prove serious.

There were numerous abscesses in both cases, but no ultimate deformity.—[*Gaillard's Med. Jour.*

Foreign Bodies in the Brain.—In an autopsy on a patient dying in one of the Vienna hospitals, it was found that he had in his brain, an iron nail covered with rust, which to all appearances must have been there since early childhood. The man was about forty-five years of age, a bookbinder, and always passed for intelligent. Negative popular evidence is of but little value. The man, at irregular intervals, had epileptic attacks, and post-epileptic mental phenomena, while in the hospital.—[*Ibid.*

Obesity and its Treatment.—Epstein, of Weisbaden, describes a new dietetic method for the relief of obesity. He does not believe in 'Bantingism,' and states that it produces inanition which may be injurious. Dr. Epstein contends that a diet of albuminous and fatty matter tends to check deposit of fat, and that it is the sugars and starches which are to be left out in an anti-fat regmen. He gives bread, however, and green vegetables, peas and beans, but no potatoes. The addition of fat to the diet list has the advantage that it produces satiety sooner and the patient does not eat so much.—[*Med. Gaz.*

An Assuager for Thirst.—Sir Joseph Fayrer, Medical Officer of the Secretary of State in India, has reported his experience in the use of coca-leaves, chewed during mountain climbing, as a means of preventing or relieving thirst. His experiment consisted in the distribution of about eighty grains of the leaf to each one of the four guides and porters who accompanied him. During the ten hours consumed by the excursion, no water and but a limited quantity of wine was consumed. They drank no tea nor coffee, nor did they use ice or snow. Nevertheless, the chewing of the coca appeared to furnish great relief from thirst, and to enable them to made the trip with comparative comfort. —[*Ibid.*

Urethritis in the Famale.—Dr. Fisséaux (*Journal de Médicine de Bordeaux*, December 16th) has had good results in the treatment of urethritis in the female by the use of saponated coal tar. A wadding tent is steeped in this compoond, introduced into the urethra, and there allowed to remain even during mic-

turition, being renewed every two days. This procedure is not attended by any unpleasant consequences, and the urethritis

---

The Certificate of Life Insufficient.—A gentleman, discovering that he has become entitled to sundry arrears of pensions, presents himself at the office to draw the money for five yields rapidly.
quarters already due.

"Where are the quarterly certificates to show that you are alive and to identify you as the person entitled to draw this money?" asked the official.

"Here it is," says the gentleman.

"Yes, but where are the others for the previous quarters?"—[*Gaillard's Med. Jour.*

The Dog Tonic.—Charles Reade, the novelist, is credited with having named a dog Tonic, because it was a mixture of bark, steal, and whine.—[*Ibid.*

Outwitting an Attempt to Evade a Fee.—The late Dr. W Gibson told the following story in regard to luxation of the jaw:

"An old, wealthy man came into the office of a surgeon with a luxation of jaw to have it reduced. This was done, but on being asked the fee, the doctor mentioned an amount which the man insisted on having reduced one half. The surgeon said no more about the fee, but began to talk and told a laughable story. The man laughed heartily, and out went the jaw. He made signs to have it reduced, but the doctor said, 'When you pay down my fee I will put in your jaw.'—[*Gaillard's Med. Jour.*

Cause and Effect.—"Alcohol," said the proffessor, "has killed more people than yellow fever,"

"That is true," said the somewhat bibulous student: "but that is only because more have taken it."

Tasteless Medicines.—An old colored man saw a sign in a in drug store which read "Tasteless medicines." Looking in at the "pizenmixer," as he called him, he said: "Dat am de bes' advice I eber got—taste less medicines," and hurried away, just in time to dodge a package which was thrown after him.

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CARD TO PHYSICIANS.

No Physician who has in his practice witnessed the beneficial results of the use of RIDGE'S FOOD, will be influenced in the slightest degree by the adverse so-called "microscopical test" arguments recently published in the several medical journals. And we respectfully call the attention of those who, unacquainted practically with its value, might be so influenced, to a recent article by Prof. Jos. G. Richardson, of the University of Pennsylvania, in the Philadelphia Medical News of June 24th, in which he shows those so-called "tests" to be a series of egregious blunders, devoid of serious consideration by any intelligent physician. Confidently leaving its scientific vindication to those really fitted by scholarship and experiment, the manufacturer of Ridge's Food simply claims—

1st. That it retains the nitrogenous elements and the phosphates in which wheat is so rich; including the substance called by a French chemist "Cerealine," a metamorphic nitrogenous bony which actes as a solvent on gluten when in presence of starch, dextrine, and glucose, exactly as pepsine acts on animal fibre.

2nd. That those elements are presented in a form which is easy of digestion and yields abundant nourishment.

3d. That the Food is acceptable to the most irritable stomach when used—as in some cases it must be—without milk, and that it will alone support life.

4th. That it is the best daily food for infants and young children, especially those who are growing.

5th. That it makes the best gruel for a nursing woman.

And finally, to use the exact language of a distinguished American medical Professor, **"The best of all is** *that it PROVES IN PRACTICE ALL THAT IT PROMISES IN THEORY."*

Respectfully, *WOOLRICH & CO., Manufrs, Palmer, Mass.*

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SACCARATED PEPSIN, which has proven its superiority over other Pepsins by its stability, uniformity and agreeable taste. In digestive power it corresponds to the standard adopted by the Committee on the 6th Revision of the U. S. Pharmacopœia which is as follows:

One part dissolved in 500 parts of water, acidulated with 7.5 parts of hydrochloric acid, should digest at least 50 parts of hard-boiled Egg Albumen in 5 to 6 hours at 100° to 104° F.

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It can be retained by the weakest stomach, when all other food extracts, and even water, is rejected.

It is the only food that will relieve the Consumptive from Hunger.

Nutritious food, if raw, condensed, and free from insoluble matter, will cure chronic diseases, as it will make blood faster than all preparations or food, and new blood will cleanse the system.

MURDOCK'S LIQUID FOOD is made from Beef, Mutton and Fruits; contains corpuscles, is 12½ per cent. soluble albumen, and free from insoluble matter, drugs, minerals, salts, and acids, and can be retained by the stomach when so weak as to refuse food.

Ask your Druggists, or send to us for Essays read before the American Medical Association at Richmond, Va., May 6, 1881, on the value of Raw-Food Extracts, by Geo. R. Shepherd, of Hartford, Conn., and other Essays and Testimonials from Medical Journals, and physicians that have used Liquid Food in cases of Consumption, Scrofula, Nervous and General Debility, Dyspepsia, Acute and Chronic, Constipation, Intemperance, Diphtheria, Cholera Infantum, Infantile Diarrhœa, Post-Partum Hemorrhage, Purpura Hemorrahgica with Waxy Liver, Pelvic Cellulitis, Malarial and other Fevers, Chronic Strumous Arthritis, Sclerosis of the Spinal Cord, Senile Gangrene, Perinephritic Abscess and other diseases of mal-nutrition. No cases of Cholera Infantum have occurred where it has been used daily, and no lives have been lost from Cholera Infantum where it has been prescribed by a physician. Excellent for Eczema, Diabetes, Rheumatism, and Neuralgia.

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The New Digestive is a combination of whole digestive secretions—Pepsine, Pancreatine, Diastase, Etc.,

Forming an invaluable remedy in the treatment of all forms of Dyspepsia, and all diseases arising from imperfect digestion.

N. B.—*The success of this remedy has led to several imitations of it*, which consist largely of Milk Sugar, and as compared with PEPTODYN, are of little or no real value as digestive agents.

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DOSE—*One-half* to *one fluid drachm* in WATER or SYRUP every hour until sleep is produced.

BROMIDIA is *the* Hypnotic *par excellence.* It produces refreshing sleep, and is *exceedingly* valuable in Sleeplessness, Nervousness, Neuralgia, Headache, Convulsions, Colic, etc., and will relieve *when opiates fail. Unlike* preparations of opium, *it does not lock up the secretions.* In the Restlessness and Delirium of Fevers *it is absolutely invaluable.*

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GELATUM VASELINE PETROLEI

Awarded Silver Medal at Paris Exposition, 1878. Medal of Progress by American Institute, 1880.

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The attention of physicians, druggists and hospitals, is called to this article, and to the fact that it is favorably regarded and extensively used in the United States, on the Continent and in England, by the profession, and by pharmacists as a base for

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As a dressing for WOUNDS, CUTS, BRUISES, BURNS, SPRAINS, PILES, RHEUMATISM, SKIN DISEASES, CATARRH, SORES OR ERUPTIVE DISEASES, and all contused and inflamed surfaces, is not equalled by any known substance.

In the treatment of COUGHS COLDS CROUP DIPHTHERIA and of THROAT and CHEST complaints the best results are obtained.

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Extracts from Report of Dr Galezowski, the distinguished French Oculist;

Vaseline is the best pharmaceutical preparation in the making of ointments, as it is completely neutral and unchangeable. I saw it used for the first time in London by Dr. Lanson. I then procured the Vaseline' myself and I have experimented with it for four months on over one thousand patients and I must declare that the knowledge acquired by practice has surpassed my expectations by far. * * * I have also prepared large quantities of eye ointments with Vaseline' and have employed them on numerous maladies with very great success and I can affirm that Vaseline' is very precious in ocular therapeutics and must replace all the ointments in use at the present time. * *

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DR. REUSCHE, of Hamburg, (*translation*) **says:**

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Applied internally it removed the small-pox in the mouth and throat in a few days.

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We have before noticed this preparation of petroleum in terms of warm praise. It is of the consistency of butter perfectly free from odor and does not become rancid. We have now before us several new preparations made from it which *are so useful* as to call for remark. They are a *pomade* a cold *cream* and a *camphor ice* all of excellent quality. We have tried all of them with most satisfactory results having found them greatly superior to the preparation in common use.

We manufacture the following Standard Ointments, according to the United States Pharmacopœa, using Vaseline as a base instead of lard:

Ung: Hydrargyri (½ Mercury). **Ung.: Zinci Oxidi.**
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We recommend them as vastly superior to anything in use. Price, 75cts, per Pound. No charge for jars. Send for Pamphlet.

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Contains **THE ESSENTIAL ELEMENTS** to the Animal Organization—
Potash and Lime;

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And the **VITALIZING CONSTITUENT**—Phosphorus,
Combined in the form of a Syrup, with *slight alkaline reaction.*

IT DIFFERS IN EFFECT FROM ALL OTHERS, being pleasant to taste, acceptable to the stomach, and harmless under prolonged use.

IT HAS SUSTAINED A HIGH REPUTATION in America and England for efficiency in the treatment of Pulmonary Tuberculosis, Chronic Bronchitis, and other affections of the respiratory organs, and is employed also in various nervous and debilitating diseases with success.

ITS CURATIVE PROPERTIES are largely attributable to Stimulant, Tonic, and Nutritive qualities, whereby the various organic functions are recruited.

IN CASES where innervating constitutional treatment is applied, and tonic treatment is desirable, this preparation will be found to act with safety and satisfaction.

IST ACTION IS PROMPT, stimulating the appetite, and the digestion, it promotes assimilation, and enters directly into the circulation with the food products.

THE PRESCRIBED DOSE produces a feeling of buoyancy, removing depression or melancholy, and hence is of great value in the treatment of **mental and nervous affections.**

From its exerting a double tonic effect and influencing a healthy flow of the secretions, its use is indicated in a wide range of diseases.

Each Bottle of Fellow's Hypophosphites contains 128 doses.

Prepared by JAMES I. FELLOWS, Chemist,

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IMPORTANT.—Our pills being coated while the mass is yet soft, will remain so for years. To be convinced of their extraordinary solubility, it is only necessary to open a few of them, for instance, quinine, chinchodia, or blue pills, all of which are usually found in the market, hard and insoluble. note also the rapidity with which the coating is dissolved in the saliva.

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One of the greatest improvements of modern pharmacy is the use of Gelatine in various forms to render medicines more sightly, and to disguise their nauseous taste. This has given origin to the Gelitine Coated Pill—a full line of which, of similar formulæ to our sugar coated pills, will be found on our list—and also to the Hard, and the Soft Gelatine Capsules. We are dispensing Hard Capsules, empty and filled. The Soft, Elastic Capsules, however, are from the nature of their formation, always filled before leaving our laboratory. These Capsules are so soft and elastic that their walls may be brought into juxtaposition, and yet they will regain their original shape and size when the pressure is removed. This property renders them very easy of deglutioion, and they will slip down like an oyster or the yelk of an egg, though the largest of them is about half the capacity of a fluidounce.

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Solution of Sicerolc Acid.
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